CenCal CareConnect

CenCal HEALTH® Local. Quality. Healthcare.

CenCal Health and CenCal CareConnect (HMO D-SNP) Authorization Request Form*

*THIS FORM DOES NOT PERTAIN TO MEDICARE PART D.

◯ URGENT/EXPEDITED** ◯ ROUTINE ◯ RETROSPECTIVE (Services Already Completed)

For a CenCal Health Medi-Cal member Fax 1-805-681-3071 or send via secure link: https://gateway.cencalhealth.org/form/hs
For a CenCal CareConnect member: Fax 1-805-681-8265 or send via secure link: https://gateway.cencalhealth.org/form/dsnp

FOR MEMBERS, OUR MAILING ADDRESS IS: CenCal Health, 4050 Calle Real, Santa Barbara, CA 93110.

IN ORDER TO PROCESS YOUR REQUEST, THIS FORM MUST BE COMPLETE AND LEGIBLE.
TO PREVENT DELAYS, PLEASE FAX ALL MEDICAL DOCUMENTS TO SUPPORT YOUR REQUEST WITH THIS FORM.

By submitting an urgent/expedited request, you confirm that this request meets the required criteria.
URGENT/EXPEDITED is only when a standard time frame for authorization will be detrimental to patient's life or health; jeopardize patient's ability to regain maximum function; or result in loss of life, limb, or other major bodily function. Urgent requests are processed within 72 hours, and urgent Medicare Part B drug requests within 24 hours.

PATIENT INFORMATION

Patient Name: _____ _____
Last First

Member ID#: _____ DOB: _____ Age: _____

Diagnosis: _____ ICD-10: _____

NEW REFERRAL AUTHORIZATION

Referring Provider:

_____

MD NPI#: _____ Group NPI#: _____

Address: _____

Office Contact: _____

Phone: _____ Fax: _____

Is the Referring Provider the PCP? ◯ YES ◯ NO

Provider Rendering Service (Physician, Facility, Vendor):

_____

MD NPI#: _____ Group NPI#: _____

Address: _____

Office Contact: _____

Phone: _____ Fax: _____

Is the Rendering Provider CCS Paneled? ◯ YES ◯ NO

FACILITY AUTHORIZATION REQUEST

◯ Inpatient Facility ◯ Outpatient Facility ◯ SNF ◯ Estimated Length of Stay: _____

Date of Services: _____ Through Date: _____

Facility NPI: _____ Facility Address: _____

Office Contact: _____ Phone: _____ Fax: _____

For Inpatient/Skilled Nursing: Please provide **BED LEVEL OF CARE:** _____

LIST ALL PROCEDURES REQUESTED ALONG WITH THE APPROPRIATE CPT/HCPCS

REQUESTED PROCEDURES:	CODE (CPT or HCPCS):	QTY (REQUIRED):	UNITS (REQUIRED):

Part B Drug/Medi-Cal Physician Administered Drug (PAD) Requests, please complete this form in its entirety to prevent delay in processing.

MEDICATION / MEDICAL AND DISPENSING INFORMATION

Medication Name:

○ New Therapy ○ Renewal ○ Step Therapy Exception Request

NDC Number:

If Renewal: Date Therapy Installed: Duration of Therapy (specific dates):

How did the patient receive the medication?

○ Paid under Insurance Name: Prior Auth Number (if known):

Other (explain):

Dose/Strength:

Frequency: Length of Therapy/#Refills: Quantity:

Administration:

○ Oral ○ Topical ○ Injection ○ IV ○ Other:

Administration Location:

○ Patient's Home ○ Physician's Office ○ Ambulatory Infusion Center

○ Long-Term Care ○ Home Care Agency ○ Outpatient Hospital Care

○ Other:

Has the patient tried any other medications for this condition? ○ YES (if yes, complete below) ○ NO

MEDICATION/THERAPY (Specify Drug Name and Dosage)	DURATION OF THERAPY (Specify Dates)	RESPONSE/REASON FOR FAILURE/ALLERGY