SHARP HEALTH PLAN
make life better.™

Medical Referral and Prior Authorization Request Form

FAX: (619) 740-8111

Incomplete forms will be faxed back.

Phone: (858) 499-8300

MEMBER NAME – LAST, FIRST, MIDDLE INITIAL *Is this a member request?* ☐ *Yes* ☐ *No*	*DATE OF BIRTH*	*HEALTH PLAN I.D. NO.*
MEMBER ADDRESS – STREET, CITY, ZIP CODE		*PATIENT PHONE NO.*
REQUESTING PROVIDER ☐ *PCP* ☐ *SPECIALIST*	*PHONE NO.* ( )	***FAX NO. (MUST HAVE FOR FAX BACK)*** ( )
PCP(IF NOT LISTED ABOVE)	*DATE PREPARED*	*PREPARED BY* / *ELIG CHECKED* ☐ yes ☐ no

☐ **Routine/Standard:** Determinations will be made within five (5) business days of receipt of all necessary information.

☐ **Urgent Request:** Determinations will be made within 72 hours of receipt of all necessary information.

PROVIDER/SERVICE REQUESTED	PROVIDER NAME	EXPECTED DATE OF SERVICE
ADDRESS – STREET, CITY, ZIP CODE	PHONE NO. ( )	**FAX NO.** ( )
☐ Inpatient ☐ Outpatient	FACILITY NAME	INPATIENT GOAL LENGTH OF STAY

DIAGNOSIS	ICD-10 CODE	PROCEDURES/EQUIPMENT	CPT CODE

REASON FOR REFERRAL (INCLUDE ALL PERTINENT DOCUMENTATION)

Payment for services is dependent upon the Patient's eligibility at the time services are rendered. Provider to call Health Plan for benefits and eligibility each visit. Prior authorization valid for ninety (90) days from date approved by Sharp Health Plan.

IMPORTANT ⇨

- **FAX completed referral forms to (619) 740-8111.**
- **Please call SHP at (858) 499-8300 if no response within 5 days.**
- **Please submit clinical documentation to support the authorization request.**

FOR SHP UM USE ONLY

Approved:	INITIALS	DATE
Pended Additional Information:	INITIALS	DATE
Denied:	INITIALS	DATE

COMMENTS:

 Rev. 10/15