



Medical Referral and Prior Authorization Request Form

Incomplete forms will be faxed back.

FAX: (619) 740-8111

Phone: (858) 499-8300

MEMBER NAME – LAST, FIRST, MIDDLE INITIAL		Is this a member request? <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE OF BIRTH	HEALTH PLAN I.D. NO.
MEMBER ADDRESS – STREET, CITY, ZIP CODE				PATIENT PHONE NO.
REQUESTING PROVIDER <input type="checkbox"/> PCP <input type="checkbox"/> SPECIALIST		PHONE NO. ()	FAX NO. (MUST HAVE FOR FAX BACK) ()	
PCP (IF NOT LISTED ABOVE)		DATE PREPARED	PREPARED BY	ELIG CHECKED <input type="checkbox"/> yes <input type="checkbox"/> 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. ()
<input type="checkbox"/> Inpatient <input type="checkbox"/> 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	<ul style="list-style-type: none"> 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:		

HIPAA Notice: The information contained in this form may contain confidential and legally privileged information. It is only for the use of the individual or entity named above. If the recipient of this form is not the recipient addressed on the form, you are hereby notified that any dissemination, distribution, or copying of the attached document(s) is strictly prohibited. If you have received this in error, please immediately notify the sender by telephone and return the form to the sender. Rev. 10/15