



Referral & Prior Authorization Request Form

Incomplete forms will be faxed back

Submit

Please submit the finished form by fax. **Fax:** 1-619-740-8111.



If you need assistance, we're here to help.

You can call Customer Care at 1-858-499-8300 or toll-free at 1-800-359-2002, or email us at customer.service@sharp.com.

We are available to assist you Monday through Friday, 8 a.m. to 6 p.m.

Member Information

First name:		Last name:		Middle initial:
Is this a member request? <input type="checkbox"/> Yes <input type="checkbox"/> No	ID#:	Birth date (MM/DD/YY): (/ /)	Member phone number: ()	
Home address:				
City:		State:		ZIP code:

Provider Information

Name of requesting provider: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist		Phone number: ()	Fax number: ()	PCP (If not listed above):	
NPI#:	Tax ID#:	Prepared by:	Date prepared (MM/DD/YY): (/ /)	Eligibility checked: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Routine/Standard Request: Determinations will be made within five (5) business days of receipt of all necessary information.					
<input type="checkbox"/> Urgent Request: Determinations will be made within 72 hours of receipt of all necessary information.					
Provider/Service requested:			Expected date of service (MM/DD/YY): (/ /)		
Provider name:		Phone number: ()		Fax number: ()	
NPI#:	Tax ID#:	Provider address:			
City:		State:		ZIP code:	
<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)

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IMPORTANT:

- FAX completed referral forms to 1-619-740-8111.
- Please call SHP at 1-858-499-8300 if no response within 5 days.
- Please submit clinical documentation to support the authorization request.

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.

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.