UCSF Health

LOA Request Form

Please fill out the following information for the LOA you are requesting and send it back via email at **hps@ucsf.edu**

Patient Name:	
Patient Date of Birth:	
MRN:	
Payer name and contact information:	
If Med Group, who is the Health Plan	
Payer product (commercial, Managed Medicare, Managed Medi-Cal, etc):	
Policy ID:	
Auth#:	
Diagnosis (ICD #) with description:	
Service (CPT) to be covered by LOA:	
Beginning effective date of LOA: (Auth From Date)	
Ending effective date of LOA: (Auth to Date)	
Date of Service:	
Department:	
Service Type? (Check one)	**INPT** ☐ **or** **OUTPT** ☐
LOA TYPE (Check one)	**Profee Only** ☐ or **Hosp/Profee** ☐
Transplant Related (Check one)	**YES** ☐ **or** **NO** ☐
Email or Fax where LOA to be returned once signed	
Name & Phone Number of Requestor	

****Please attach hard copy of authorization if obtained.**