Alignment Healthcare Fax

To:
Company:
Fax: 813-558-6466
Phone:

From:
Fax: 5622074628
Phone:
E-mail: UMDeptFax@ahcusa.com

NOTES:

PLEASE FILL OUT ENTIRE FORM, PROVIDE A BRIEF CLINICAL JUSTIFICATION AS TO WHY THE PT IS BEING REFERRED AND ATTACHED CLINICAL NOTES,
NO RANGE CODE ACCEPTIED

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Alignment Healthcare

PRIOR AUTHORIZATION REQUEST

For assistance contact the Referrals/Authorizations Department at: Telephone (844) 783-5191
Please complete the following in its entirety and fax it back along with clinical documentation to support your request to: Fax (844) 361-4707

Practice Location: _____ Date: _____ PCP: _____

Priority

☐ Urgent - Expedited/Urgent is defined: 'in which the routine referral process could seriously jeopardize the life and health of the member, or the member's ability to regain maximum function.'

☐ Routine

Health Plan Member ID No.: _____

Patients Name (Please Print) Last,	First	Middle	Sex	Date of Birth
Address	**City**	**State**	**Zip**	**Telephone**

Type of Service (Check, if applicable)

HOSPITAL

☐ Outpatient ☐ Inpatient ☐ Specialty Office ☐ Diagnostic Imaging ☐ Dialysis ☐ Chemotherapy

Referred to Physician/ Facility: _____ Specialty: _____

Address: _____ Phone: _____ Fax: _____

Diagnosis: _____ ICD-10 Code(s): _____, _____, _____

Procedure: _____ CPT Code(s): _____, _____, _____

(Indicate quantities)

Document Clinical Justification (and attach pertinent progress notes/diagnostic studies):

_____

_____

_____

Requesting Physician: _____ Telephone No.: _____

Person Completing Form: _____ Telephone No. and Ext.: _____ Fax No.: _____

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