CLEAR FORM

HealthPlan OF SAN MATEO

Prior Authorization Request Form

Fax completed form to 650-829-2079.

Please type into PDF form and fill out all fields.

REQUEST

- ☐ URGENT
- ☑ ROUTINE

Mark ✓or X

LINE OF BUSINESS

- ☐ CAREADVANTAGE
- ☐ MEDI-CAL
- ☐ ACE
- ☐ HEALTHWORX

Today's Date: _____ MM-DD-YYYY

Is member currently in the hospital? ☐ **YES** ☐ **NO** **IF YES, FAX Facesheet to 650-829-2060**

➢ **Member Last Name:** _____ First Name, M.I.: _____

Street Address: _____ City, State, ZIP: _____

Phone: _____ Member ID#: _____ DOB: _____ Age: _____

➢ **Servicing Provider Name:** Stanford Children's Rehabilitation Services NPI: 1417907940

Street Address: 321 Middlefield Road City, State, ZIP: Menlo Park, CA 94025

Phone: (650) 736-2000 Fax: (408) 579-6144 Office Contact: _____

➢ **Additional Provider (if needed):** _____ NPI: _____

Primary Diagnosis Code: _____ **Description:** _____

Secondary Diagnosis Code: _____ **Description:** _____

Tertiary Diagnosis Code: _____ **Description:** _____

Line No.	Procedure Code (CPT/HCPCS Code/Modifier if applicable)	Specific Services Requested	Units of Service (Days/Quantity)
1	x3920	Outpatient Physical Therapy Evaluation	1
2	x3922	Physical Therapy Any Test Measure Add 15 min, Plu	2
3			
4			
5			
6			
7			
8			
9			
10			

Optional comments for medical justification. Requesting Provider please attach required medical records/supporting documents.

INPATIENT ONLY – LTC Required Information (*Mark ✓or X*):

☐ Transfer ☐ Initial ☐ Reauthorization ☐ Bed Hold ☐ Skilled Nursing ☐ ICF-DD ☐ Sub-Acute

Requested Service Dates FROM: MM-DD-YYYY **TO:** MM-DD-YYYY

To the best of my knowledge, the above information is true, accurate and complete, and the requested services are medically indicated and necessary to the health of the patient.

Signature of Physician or Provider **Title** **Date** MM-DD-YYYY

PRINT FORM