HealthPlan OF SAN MATEO

HPSM Prior Authorization Request Form
User Guide for Providers

LINE OF BUSINESS: ALL

EFFECTIVE: June 1, 2017

HPMS requires this form to be completed via computer/typed (not hand written) and faxed (as page one) to 650-829-2079

The new Prior Authorization Request Form will replace the current Prior Authorization Request form as well as the old 50-1, 18-1, and 20-1 forms. This form is fillable via computer and can be used to request services for all lines of business. Please check the Prior Authorization Required Services List which can be found on our website https://www.hpsm.org/providers/authorizations.aspx prior to submission.

HealthPlan OF SAN MATEO

Prior Authorization Request Form

Please type into PDF form and fill out all fields.
Fax completed form to 650-829-2079.

1 REQUEST: ☐ URGENT ☐ ROUTINE

2 LINE OF BUSINESS: ☐ CAREADVANTAGE ☐ MEDI-CAL ☐ ACE ☐ HEALTHYKIDS ☐ HEALTHWORX

Mark ✓ or X

3 Today's Date: _____ MM-DD-YYYY

Is this a Pharmacy request? ☐ YES ☐ NO IF YES, FAX Form to 650-829-2045

4 Is this a retrospective request? ☐ YES ☐ NO IF YES, FAX to 650-829-2062

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

1. Indicate if this request is Urgent or Routine with a check in one box
   Definition of Urgent: A request for medical care or services where using the routine time frame to make medical determinations could seriously jeopardize the life, health or safety of the member or would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

2. Choose ONE Line of Business with a check in one box. Please check member's eligibility or check member's ID card
3. Type in today's date
4. ● If this is a pharmacy request or pertaining to medications, please fill out the Pharmacy Authorization Form and fax to 650-829-2045. This is located under the Pharmacy tab: https://www.hpsm.org/providers/provider-resources.aspx
   ● If this is a request for retrospective review (ALL services have already been completed), please fax to 650-829-2062
   ● If this is an inpatient admission, please fax a facesheet to 650-829-2060

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

Street Address: _____ City, State, ZIP: _____

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

6 ➢ **Servicing Provider Name:** _____ NPI: _____

Street Address: _____ City, State, ZIP: _____

Phone: _____ Fax: _____ Office Contact: _____

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

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

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

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

5. Please enter member information. If this member belongs to a Landmark Cohort, indicate Yes
6. Enter info for provider/facility who will be rendering/performing the service (not PCP). Please enter the specific contact phone number, fax, and name of the person/office that needs to be notified of a decision on the last line.
7. Enter any additional providers/NPIs involved in the service (ex. the NPI for the facility, surgeon, assistant surgeon, or medical group)
8. Enter diagnosis code and description, use ICD-9 before Sept. 30, 2015 and use ICD-10 starting Oct. 1, 2015

9

Line No.	Procedure Code (CPT/HCPCS Code/Modifier if applicable)	Specific Services Requested	Units of Service (Days/Quantity)
1.			
2.			

9. Enter procedure code, description of services requested, and specify the units of service (ex. 13 units or 13 months). Please check the Prior Authorization Required Services List which can be found on our website https://www.hpsm.org/providers/authorizations.aspx

10

Comments: Medical Justification (For Requesting Provider Use – Medical Records/Supporting Documents Required – Please Attach)

10. Enter comments and specific information, supporting documents are required. If there is a current authorization that needs to have the end date changed enter that info here.

11

Long Term Care (LTC) Required Information **(Please mark "X")**

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

11. For Long Term Care requests, please mark with a check in one box

12

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

13

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

12. Enter service dates
13. Sign the form, enter title and date
14. Save a copy of the form for your records
15. Print the form, attach supporting documents, and fax to 650-829-2079