Long-Term Care (LTC) –Authorization Request Form (ARF)
(for Ancillary Services)

The Alameda Alliance for Health (Alliance) Long-Term Care (LTC) Department –Authorization Request Form (ARF) *(for Ancillary Services)* is confidential. Filling out this form will help us better serve our members. Authorizations are based on medical necessity and covered services. Authorizations are contingent upon the member's eligibility and are not a guarantee of payment. The provider is responsible for verifying the member's eligibility on the date of service. Member must be eligible on the date of service and procedure must be a covered benefit. **THE REMAINING BALANCE MAY NOT BE BILLED TO THE PATIENT.**

INSTRUCTIONS

1. Please type in all of the fields below. All fields with an (*) are required. Do not handwrite or stamp.
2. Please fax the completed form to the Alliance Long-Term Care (LTC) Department at **1.510.747.4191**.

For questions, please call the Alliance LTC Department at **1.510.747.4516**.

☐ *Clinicals are required to be submitted with this form. Please check this box to certify clinicals have been attached.

*SECTION 1: TYPE OF REQUEST	SECTION 2: REQUESTING PROVIDER
Please select only one (1): ☐ **Routine** – Approval based on Alliance clinical review. The Alliance has up to five (5) business days to process routine requests. ☐ **Urgent** – Inappropriate use will be monitored. The Alliance has up to 72 hours to process urgent requests for all lines of business. ☐ **Retro** – Only granted for member eligibility issues on DOS or for services rendered in emergent or urgent situations. The Alliance has up to 30 calendar days to process retro requests. ☐ **Modification** – Request for existing authorized services. Please enter the Alliance Auth # and the member information below. Use a separate sheet to specify your changes or to attach additional supporting documentation. *If **Modification**, Alliance Auth #: _____	*Last Name: _____ *First Name: _____ Address: _____ City: _____ State: _____ Zip Code: _____ *NPI #: _____ *TIN: _____ Office Contact: _____ *Phone Number: _____ *Fax Number: _____ Email: _____

SECTION 3: MEMBER INFORMATION

*Last Name: _____ *First Name: _____

*Date of Birth (MM/DD/YYYY): _____ *Alliance Member ID #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Primary Insurance: _____

SECTION 4: RENDERING PROVIDER/FACILITY INFORMATION

*Name/Facility: _____ *Phone Number: _____

Specialty/Dept.: _____ *Fax Number: _____

*NPI #: _____ *TIN: _____ Address: _____

Date of Service From: _____ To: _____ City: _____ State: _____ Zip Code: _____

*Place of Service (Please select only one (1)):

☐ Ambulatory Surgical Ctr. ☐ Custodial ☐ DME ☐ ICF

☐ Outpatient Hospital ☐ Provider's Office ☐ Skilled ☐ Subacute

*Non-Contracted (Please select only one (1)):

☐ Patient Request ☐ Provider not accepting new patients ☐ Provider not available

☐ Specialized procedure/ area of expertise ☐ Timely access to the provider ☐ Other specify: _____

SECTION 5: DIAGNOSIS/SERVICE CODES

Please DO NOT describe the procedures; only enter the Code, Modifier (MOD), and Quantity (QTY).

*ICD-10 Code(s):									

*CPT/HCPCS	MOD	*QTY	CPT/HCPCS	MOD	QTY	CPT/HCPCS	MOD	QTY