Don't Handwrite or Stamp!

1. Download this PDF file and type.
2. All highlighted fields are required.
3. Print and Fax the typed form.

Prior Authorization Request

Fax: (855) 891-7174 **Phone:** (510) 747-4540

Note: All **HIGHLIGHTED fields** are required.
Handwritten or incomplete forms may be delayed.

Authorizations are based on medical necessity and covered services. Authorizations are contingent upon member's eligibility and are not a guarantee of payment. The provider is responsible for verifying member's eligibility on the date of service.

Member must be eligible on date of service and procedure must be a covered benefit. REMAINING BALANCE MAY NOT BE BILLED TO THE PATIENT. If interested in becoming an Alliance contracted provider or to verify eligibility, contact Provider Services at (510) 747-4510 or visit https://www.alamedaalliance.org.

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

MEMBER (For newborn services provide mother's information)

First Name:	**Health Plan ID#:**
Last Name:	Phone:
Date of Birth:	Other Insurance (i.e. Commercial, Medicare A, B):
Address:	
City: State: Zip:	

RENDERING PROVIDER/FACILITY

Name/Facility:		Phone:
Specialty/Dept:		Fax:
NPI #:	**TIN #:**	Address:
Date of Service From:	To:	City: State: Zip:
PLACE OF SERVICE (Check one – please do not circle): Inpatient Hospital; Ambulatory Surgical Ctr.; Outpatient Hospital; Home; Provider's Office; DME		**Non-Contracted.** Provide reason for out of network request.

DIAGNOSES / SERVICE CODES **Please DO NOT describe the procedures; only enter the Code, Modifier, and Quantity.**

ICD-10 Code(s):									

CPT/HCPCS	Mod	**Qty**	CPT/HCPCS	Mod	Qty	CPT/HCPCS	Mod	Qty	CPT/HCPCS	Mod	Qty

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