Blue Zones Health - Prior Authorization Request Form

Providers may utilize the Blue Zones Health Provider Portal:

- **Claims Submission and Status**
- **Authorization Submission and Status**
- **Member Eligibility**

Fax Number:
For Anthem Members Only: 424-210-9420
For all others: 818-921-3123

MEMBER INFORMATION

Line of Business:	☐ **Duals**	☐ **Medicare**	☐**CA EAE (Medicaid)**	**Date of Request:**
Health Plan:				
Member Name:			**DOB (MM/DD/YYYY)**	
Member ID#:			**Member Phone:**	
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Other (Please Specify): ☐ Inpatient ER Admission (Concurrent) ☐ EPSDT/Special Services ☐ CA IPA request: Medicare Denial, requires Medicaid/LTC Review ☐ Continuity of Care (COC)		☐ Urgent (Rationale):	

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	☐ **Initial Request**	☐ **Extension/Renewal/Amendment**	☐ **Previous Auth #**

Inpatient Services:	**Outpatient Services:**		
☐Inpatient Hospital	☐Chiropractic	☐Infusion Therapy	☐ Partial Hospitalization Program
☐Inpatient Transplant	☐Dialysis	☐Intensive Outpatient Program	☐Physical Therapy
☐Inpatient Hospice	☐DME	☐Laboratory Services	☐Radiation Therapy
☐Long Term Acute (LTAC)	☐Electroconvulsive Therapy	☐LTSS Services	☐Speech Therapy
☐Acute Inpatient Rehabilitation (AIR)	☐Genetic Testing	☐Occupational Therapy	☐Transplant/Gene Therapy
☐Skilled Nursing (SNF)	☐Home Health	☐Office Procedures	☐Transportation
☐Other Inpatient: _____	☐Hospice	☐Outpatient Surgical/Procedures	☐Wound Care
	☐Hyperbaric Therapy	☐Pain Management	☐ Other:
	☐Imaging/Special Tests	☐Palliative Care	
		☐Pharmacy	

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code: **Description:**

DATES OF SERVICE Start	Stop	PROCEDURE/SERVICES CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS

PROVIDER INFORMATION

Requesting/Referring Provider/Facility:

Provider Name:		**NPI#:**	**TIN#:**
Phone:	**Fax:**	**Email:**	
Address:	**City:**	**State:**	**Zip:**
PCP Name:		**PCP Phone:**	
Office Contact Name:		**Office Contact Phone:**	

Servicing/Billing Provider/Facility:

Provider/Facility Name (Required):

NPI#	**TIN#**	**Medicaid/Medicare ID (If Non-Par):**	☐ **Non-Par**	☐ **COC**
Phone:	**Fax:**	**Email:**		
Address:	**City:**	**State:**	**Zip:**	

For Blue Zones Health Use Only:

Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility on the date of service, benefit limitations/exclusions and other applicable standards during the claim review, including the terms of any applicable provider agreement.