



INPATIENT AUTH REQUEST FAX COVER SHEET

(Call Provider Line at 800-798-2254, Option 3, then fax to 866-220-4495)

Date: _____ Client Name: _____ #of Pages (including cover sheet): _____
Hospital Name: _____ Facility Type: ☐ Fee for Service, ☐ Short Doyle
Intake Point of Contact: _____ Phone #: _____ Fax #: _____
UR Point of Contact: _____ Phone #: _____ Fax #: _____

Admission & Insurance Information (required upon initial request and as changes occur):

Admit Date: _____ Medi-Cal or SSN: _____
Attending Physician: _____ Client DOB: _____
Legal Status: _____ San Diego Medi-Cal: Yes No
(72hr/ 14 day/ 30 day/ T-Con/ P-Con/ Voluntary) If MediCare/OHC - Start date of Medi-Cal Coverage: _____
Reason for Admission: ☐ DTS ☐ DTO ☐ GD ☐ OTHER ☒ Must include EOB or Letter of Non-Coverage

☐ Admit Auth Request:

Days Requested (up to 3 Acute, up to 1 Admin)

Acute #: _____ Start date Acute: _____

Admin #: _____ Start date Admin: _____

Documents Required:

- ✓ Complete Face Sheet
(See Appendix 1 of Optum Auth Request Process)
- ✓ Admission Orders
- ✓ Initial Plan of Care
(See Appendix 2 of Optum Auth Request Process)
- ✓ If Admin Day, Disposition Plan/Location
Call Logs (if applicable)

☐ Continued Auth Request:

Days Requested (up to 4 Acute, up to 7 Admin)

End Date of previous Authorization: _____

Acute #: _____ Start date Acute: _____

Admin #: _____ Start date Admin: _____

Documents Required:

- ✓ Continued Plan of Care
(See Appendix 3 of Optum Auth Request Process)
- ✓ Additional Information
- ✓ If Admin Day, Disposition Plan/Location
Call Logs (if applicable)

☐ Expedited/Informal Appeal:

(Submit within 2 business days of NOABD fax Date)

First denied date of service(s) on NOABD: _____

Documents Required:

- ✓ Updated Plan of Care/Additional Information

☐ Discharge:

- ✓ Admission Date:
- ✓ Dates of Acute Days:
- ✓ Dates of Admin Days:
- ✓ Discharge Date:

Documents Required:

- ✓ Discharge Plan/Summary

Clinical Consultation (unrelated to NOABD):

Updated # of days requested (up to 4 Acute, up to 1 Admin)

Acute #: _____ Start date Acute: _____

Admin #: _____ Start date Admin: _____

Documents Required:

- ✓ Updated Plan of Care/Additional Information

Notice of Disclosure and Confidentiality

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