

California Counties ~ Value Options

Fax Authorization Requests for Out of County Medi-CAL

Fax Line: **855-524-6067**

Form Must be **Filled Out In Its Entirety** to be Processed

(PLEASE PRINT LEGIBLY)

Your Name: _____

Phone#: (____) _____ Fax#: (____) _____

Provider Name: _____ **Please list fax # where we are to fax**

Phone#: (____) _____ **this authorization form back to.**

Address where services are rendered to Member: _____

City: _____ State: _____ Zip: _____

County where services are rendered to Member: _____

Member Name: _____ DOB: ____/____/____

Address where Member is now living: _____

City: _____ State: _____ Zip: _____

County of Residence: _____

SSN: _____ - _____ - _____ Medi-Cal #:

--	--	--	--	--	--	--	--	--	--

Placement: Foster Care / Group Home / Adoptive Home / Relative Care/ OTHER: _____

Gender: M / F Ethnicity: _____

Authorization Start Date Requested: ____/____/____ ****We will NOT start authorization before**

Type of Auth: New / Concurrent **the date we receive this form in our office****

Type of Service: Assessment only/Outpatient Therapy / Medication Mngt or 90862 or 90805 or 90807 / Psychological-Testing / Case Conference

Special Notes: _____

=====

For Internal Use Only:

Eligibility Verified _____ Home County: _____

****If county of origin is San Bernardino, San Francisco, Alameda, Amador, Butte, or Calaveras, verify the required clinical form is attached before authorizing****

Auth Number: _____ - _____ - _____

Type: _____ # of Sessions: _____ Effective Date: ____/____/____ Exp Date: ____/____/____ CM/CSA: _____

Type: _____ # of Sessions: _____ Effective Date: ____/____/____ Exp Date: ____/____/____ CM/CSA: _____