


# SHARP Health Plan

<b>OFFICE USE ONLY</b> Eligibility verified: <input type="checkbox"/> Yes <input type="checkbox"/> No
---

## Medicare Advantage

# Prior Authorization Request Form

<p><b>Purpose</b></p> <p>The purpose of this form is to request prior authorization for a Sharp Direct Advantage member so they may receive health services.</p> <p><b>Instructions</b></p> <p>Fill out all applicable sections completely and legibly. Attach clinical documentation, such as progress notes, labs or radiology, to support the authorization request.</p>	<p><b>Submit</b></p> <p>Please fax the finished form to:</p> <p> Attention: Medical Management 1-858-636-2426</p> <p><b>Need help?</b></p> <p>Call Customer Care at 1-855-562-8853 (TTY/TDD: 711), or email customer.service@sharp.com with your message. We're available to assist you 7 a.m. to 8 p.m., seven days a week.</p>
---	---

Member Information			
First name:	Last name:	Middle initial:	
Is this a member request? <input type="checkbox"/> Yes <input type="checkbox"/> No	Member ID#:	Birth date (MM/DD/YY):	Member phone number:
Home address:			
City:	State:	ZIP code:	
Provider Information			
Name of requesting provider: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist		Date prepared (MM/DD/YY):	
Phone number:	Fax number:	Prepared by:	
PCP (If not listed above):	NPI#:	Tax ID#:	
<input type="checkbox"/> <b>Routine/Standard Request:</b> Determinations will be made within fourteen (14) calendar days of receipt of all necessary information. <input type="checkbox"/> <b>Urgent Request:</b> Determinations will be made within 72 hours of receipt of all necessary information. <input type="checkbox"/> <b>Routine/Standard Request Part B Medication:</b> Determination will be made within 72 hours of receipt of all necessary information. <input type="checkbox"/> <b>Urgent Request Part B Medication:</b> Determination will be made within 24 hours of receipt of all necessary information.			

Provider Information, continued			
Provider/Service requested:		Expected date of service (MM/DD/YY):	
Provider name:		Phone number:	Fax number:
NPI#:	Tax ID#:	Provider address:	
City:		State:	ZIP code:
<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	Facility name:		Inpatient goal length of stay:
Diagnosis	ICD-10 Code	Procedures/Equipment	CPT Code
Reason for referral (include all pertinent documentation)			

**IMPORTANT:**

- FAX completed referral forms to 1-858-636-2426.
- Please call SHP at 1-858-499-8300 if no response within 5 days.
- Please submit clinical documentation to support the authorization request.

Payment for services is dependent upon the patient's eligibility at the time services are rendered. Provider to call Health Plan for benefits and eligibility each visit. Prior authorization valid for ninety (90) days from date approved by Sharp Health Plan.

HIPAA Notice: The information contained in this form may contain confidential and legally privileged information. It is only for the use of the individual or entity named above. If the recipient of this form is not the recipient addressed on the form, you are hereby notified that any dissemination, distribution, or copying of the attached document(s) is strictly prohibited. If you have received this in error, please immediately notify the sender by telephone and return the form to the sender.