



AUTHORIZATION REQUEST FORM

Paper forms should be used only when necessary and must be filled out fully to be processed. Complete fax forms electronically or print clearly to avoid delays. Sign up for HillLink today to begin submitting Authorizations electronically and speed up turnaround times. Visit our Provider Portal @ <https://providers.hillphysicians.com> to request Provider Portal Access and sign up for HillLink!

Fax Elective and Retro To:
East Bay, SF, Solano - **844-449-3492**
Sacramento - **844-449-3493**
San Joaquin - **844-449-3494**

Please Check Type	<input type="checkbox"/> Elective	DOS ___/___/___	<input type="checkbox"/> Urgent, Please fax to (855) 874-2884 (for all regions)
	<input type="checkbox"/> Retro	DOS ___/___/___	(Scheduling does not qualify for urgent status.)

PATIENT INFORMATION

Last Name	First Name	MI	Subscriber # (or Member ID #)
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Address	City	State	Zip	Primary Care Physician (PCP)
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Date of Birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number ()	Work Phone Number ()
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Health Plan	<input type="checkbox"/> Bright Health	<input type="checkbox"/> Health Net	Please Check Product
<input type="checkbox"/> Aetna	<input type="checkbox"/> Central Health	<input type="checkbox"/> Hill Physicians Care Solutions (HPCS)—Health Net	
<input type="checkbox"/> Anthem Blue Cross	<input type="checkbox"/> Canopy Health	<input type="checkbox"/> Hill Physicians Care Solutions (HPCS)—UnitedHealthcare	
<input type="checkbox"/> Blue Shield/CalPERS	<input type="checkbox"/> Chinese Community Health Plan (CCHP)	<input type="checkbox"/> Humana	
<input type="checkbox"/> Blue Shield HMO	<input type="checkbox"/> CIGNA	<input type="checkbox"/> Oscar <input type="checkbox"/> UnitedHealthcare	
<input type="checkbox"/> Brand New Day		<input type="checkbox"/> SF Health Plan <input type="checkbox"/> WHA	
			<input type="checkbox"/> Commercial
			<input type="checkbox"/> Medicare
			<input type="checkbox"/> Medi-Cal
			<input type="checkbox"/> CCS dx Verify & use CCS referral

PROVIDER INFORMATION

Requesting Provider	<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Consultant	Last Name	First Name	MI
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Contact Person	Phone Number ()	Fax Number for Auth Status ()
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Signature or Stamp Required (Requesting Physician)	NPI #	Date Signed / /
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REQUESTED SERVICE(S) INFORMATION

Yes, this request is to change an existing Authorization.

Authorization # _____ Change from _____ Change to _____

Requested Service Type:	<input type="checkbox"/> Patient Request	<input type="checkbox"/> Outpatient	<input type="checkbox"/> In-Patient	<input type="checkbox"/> Observation	<input type="checkbox"/> DME
	<input type="checkbox"/> Home Health	<input type="checkbox"/> Office	<input type="checkbox"/> 2nd Opinion	<input type="checkbox"/> Out of Network	<input type="checkbox"/> Other

Provider Name	NPI #	Assistant Surgeon <input type="checkbox"/> Yes <input type="checkbox"/> No
Place of Service / Address	Name	

ICD-10 Code(s) with Description

CPT/J-(Drug)/E-(DME) Code(s) with Description (be specific, i.e. - Rt/Lt, weight, dosage where applicable)
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Please complete and/or attach diagnosis, clinical problem, history, date of onset, relevant prior treatment(s) & outcome(s), diagnostic imaging results, clinical documentation, labs, and/or consult reports or contact info for out-of-network.

For more information, contact Hill Physicians' Customer Service at (800) 445-5747.

All services billed are subject to ClaimXten® review. The authorization and payment for requested services is approved based on the member's HMO eligibility and benefit information available at the time service is rendered.

HIPAA Notice: It is unlawful for unauthorized persons to review, copy, disclose, or disseminate confidential medical information. If the reader of this warning is not the intended recipient, or the intended recipient's agent, you are hereby notified that you have received this message in error and that review of this information is strictly prohibited. If you have received this transmission in error, please notify us immediately at the telephone number listed above. It is also requested that you immediately send this transmission to our office at the fax number listed above. Thank you.