REQUEST FOR CATARACT SURGERY

Foundation Authorization Request Form

Fax completed form to 707-442-2047 or mail to the Foundation, P.O. Box 1395, Eureka, CA 95502

Incomplete request forms will be returned without being processed. A copy of this form should be kept in the patient's chart.
Notification will be sent to the member, the requesting provider, the member's PCP (if different than the requesting) and the proposed provider.

Foundation Authorization Tracking #:

MEMBER INFORMATION

Patient Name:_____ Gender: M / F Date of Birth:_____

Patient's Address:_____
Street City Zip Phone

Health Plan: Anthem Blue Cross HMO/POS - Blue Shield HMO - Blue Lake Rancheria - Trinidad Rancheria

Subscriber Name: _____ Group #:_____

Member's Primary Care Provider:_____ Subscriber #:_____

REQUESTING PROVIDER INFORMATION	PROPOSED PROVIDER & FACILITY INFORMATION
Name:	Name:
Address:	Address:
City, State, ZIP:	City, State, ZIP:
Phone: Fax:	Phone: Fax:
Contact Name:	Tax ID # (Out of Area Providers only):
Today's Date:	Place of Service:

Type of Request (circle): Routine Retroactive Date of Service: _____

Primary Diagnosis:	Secondary Diagnosis:
☐ Cataract ICD-9: _____	ICD-9: _____

Requested Service :
Description:_____ **CPT:** _____ Quantity _____
Description:_____ **CPT:** _____ Quantity _____
Description:_____ **CPT:** _____ Quantity _____
Description:_____ **CPT:** _____ Quantity _____
Description:_____ **CPT:** _____ Quantity _____

In order to process this request the following medical necessity information must also be provided:

Date first diagnosed: _____ Circle one: OD OS OU

Is functional visual impairment present related to the cataract(s): Yes No

Additional comments:

- Approved authorizations are effective from the date they are received and expire three (3) months from the effective date and are based on the member's eligibility at the time the authorization is reviewed. Providers must verify member eligibility within 5 days of the date of service to ensure coverage..
- Claims for services rendered without required prior authorization may be denied reimbursement. Claims for the above services must be submitted for the same service, CPT code and provider group (tax id #) as those approved or documentation must be submitted to explain the medical necessity of alternative and/or additional services.
- The requesting physician or the member may submit authorization appeals to the Foundation Medical Management Department.
- This is confidential and privileged information protected by California Civil Code § 43.97, Health & Safety Code §1370, and California Evidence Code §1157.

IMPORTANT WARNING

This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is **STRICTLY PROHIBITED**. If you have received this message by error, please notify us immediately and destroy the related message. You, the recipient are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.