

## 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.

<b>Foundation Authorization Tracking #:</b>	
<b>MEMBER INFORMATION</b>	
Patient Name: _____ Gender: <u>M</u> / <u>F</u> Date of Birth: _____	
Patient's Address: _____ <div style="display: flex; justify-content: space-between; width: 100%;"> <span>Street</span> <span>City</span> <span>Zip</span> </div>	
Phone: _____	
Health Plan: California Care(Blue Cross HMO/POS) - PALCO - St. Joseph Hospital/RMH - Trinidad Rancheria - Blue Lake Rancheria - Blue Shield HMO	
Subscriber Name: _____ Group #: _____	
Member's Primary Care Provider: _____ Subscriber #: _____	
<b>REQUESTING PROVIDER INFORMATION</b>	<b>PROPOSED PROVIDER &amp; FACILITY INFORMATION</b>
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: _____
<b>REQUESTED SERVICES AND MEDICAL NECESSITY</b>	
Diagnosis Description: _____ ICD9(s): _____	
Relevant Clinical Information (and/or send medical notes): _____ _____ _____	
Requested Service:    Description: _____ CPT: _____ Quantity _____	
Description: _____ CPT: _____ Quantity _____	
Description: _____ CPT: _____ Quantity _____	
Description: _____ CPT: _____ Quantity _____	
Check if requesting surgical assist <input type="checkbox"/>	
Type of Request (circle):    Routine    Outpatient    Inpatient    Date _____	
Retroactive (include notes) Date _____    Emergent / Urgent (include notes)	

- Authorizations are effective from the date they are received and expire three (3) months from the effective date.
- Authorizations are based on the member's current eligibility.
- 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.

### CONFIDENTIAL INFORMATION

This facsimile 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.