IMPORTANT: Incomplete forms will be faxed back to sender.

SHARP Health Plan

OFFICE USE ONLY
Eligibility verified:
☐ Yes ☐ No

Medicare Advantage

Prior Authorization Request Form

Purpose

The purpose of this form is to request prior authorization for a Sharp Direct Advantage member so they may receive health services.

Instructions

Fill out all applicable sections completely and legibly. Attach clinical documentation, such as progress notes, labs or radiology, to support the authorization request.

Submit

Please fax the finished form to:

Attention: Medical Management
1-858-636-2426

Need help?

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.

Member Information			
First name:	Last name:		Middle initial:
Is this a member request? ☐ Yes ☐ No	Member ID#:	Birth date (MM/DD/YY):	Member phone number:
Home address:			
City:	State:		ZIP code:

Provider Information			
Name of requesting provider: ☐ PCP ☐ Specialist		Date prepared (MM/DD/YY):	
Phone number:	Fax number:		Prepared by:
PCP (If not listed above):	NPI#:	Tax ID#:	

☐ **Routine/Standard Request:** Determinations will be made within fourteen (14) calendar days of receipt of all necessary information.

☐ **Urgent Request:** Determinations will be made within 72 hours of receipt of all necessary information.

☐ **Routine/Standard Request Part B Medication:** Determination will be made within 72 hours of receipt of all necessary information.

☐ **Urgent Request Part B Medication:** 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:
☐ Inpatient ☐ 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.