HealthPlan OF SAN MATEO
Healthy is for everyone

801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080

tel 650.616.0050
fax 650.616.0060
tty 800.735.2929 or dial 7-1-1

www.hpsm.org

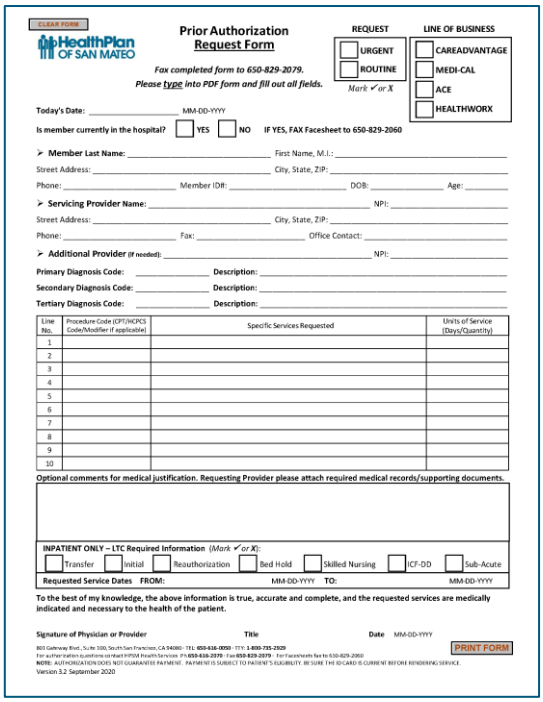
March 16, 2021

Reminder: Make Sure You're Using Our Current Prior Authorization Request Form

Dear Provider,

Earlier this year we updated our prior authorization form, which is available online. This new form will help us process prior authorization requests more efficiently. If you have not, please begin using this template immediately.

The current form is version 3.2 and is dated September 2020. You can find it at www.hpsm.org/provider/authorizations.



CLEAR FORM

HealthPlan OF SAN MATEO

Prior Authorization Request Form

Fax completed form to 650-829-2079.
Please type into PDF form and fill out all fields.

REQUEST: ☐ URGENT ☐ ROUTINE (*Mark ✓ or X*)

LINE OF BUSINESS: ☐ CAREADVANTAGE ☐ MEDI-CAL ☐ ACE ☐ HEALTHWORX

Today's Date: _____ MM-DD-YYYY

Is member currently in the hospital? ☐ YES ☐ NO IF YES, FAX Facesheet to 650-829-2060

➢ **Member Last Name:** _____ First Name, M.I.: _____
Street Address: _____ City, State, ZIP: _____
Phone: _____ Member ID#: _____ DOB: _____ Age: _____

➢ **Servicing Provider Name:** _____ NPI: _____
Street Address: _____ City, State, ZIP: _____
Phone: _____ Fax: _____ Office Contact: _____

➢ **Additional Provider** (If needed): _____ NPI: _____

Primary Diagnosis Code: _____ **Description:** _____
Secondary Diagnosis Code: _____ **Description:** _____
Tertiary Diagnosis Code: _____ **Description:** _____

Line No.	Procedure Code (CPT/HCPCS Code/Modifier if applicable)	Specific Services Requested	Units of Service (Days/Quantity)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Optional comments for medical justification. Requesting Provider please attach required medical records/supporting documents.

INPATIENT ONLY – LTC Required Information (*Mark ✓ or X*):
☐ Transfer ☐ Initial ☐ Reauthorization ☐ Bed Hold ☐ Skilled Nursing ☐ ICF-DD ☐ Sub-Acute

Requested Service Dates FROM: MM-DD-YYYY **TO:** MM-DD-YYYY

To the best of my knowledge, the above information is true, accurate and complete, and the requested services are medically indicated and necessary to the health of the patient.

Signature of Physician or Provider **Title** **Date** MM-DD-YYYY

PRINT FORM

800 Gateway Blvd., Suite 100, South San Francisco, CA 94080 - TEL: **650-616-2050** - TTY: **1-800-735-2929**
For authorization questions contact HPSM Health Services. PH **650-616-2070** - Fax **650-829-2079** - For Facesheets fax to 650-829-2060
NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE ID CARD IS CURRENT BEFORE RENDERING SERVICE.
Version 3.2 September 2020

Here is an image of what the current form looks like. Use these tips to ensure your authorization is processed as quickly as possible:

☐ You complete all fields using the fillable PDF (typed, not handwritten).

☐ You use one form for one patient and double-check the member ID number before sending. Note that we cannot process more than one patient per form.

☐ You set your fax machine settings to the highest quality possible.

☐ Bookmark HPSM's authorizations page (link above) and regularly check the Prior Authorization Required list to determine if prior authorization is required.

Thank you,

The Health Plan of San Mateo