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

February 17, 2023

Prior Authorization Request Form Reminder

Dear provider,

We recently noticed a rising number of providers marking “urgent” for routine requests on the prior authorization request form.

Requests that are urgent are based on the need of the member. “Urgent” should only be used when our turnaround time can/may cause serious harm to a member's life and health (our turnaround time for all non-urgent prior authorization requests is five days). Most requests should be marked as “routine.”

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

801 Gateway Blvd., Suite 100, South San Francisco, CA 94080 · TEL: **650-616-0050** · 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

Find our prior authorization request form and additional resources here:

www.hpsm.org/provider/authorizations

Questions? Please email HPSM Provider Services at **PSInquiries@hpsm.org**.

Thank you for your continued commitment to our community,

HPSM Provider Services