ALAMEDA Alliance FOR HEALTH
Health care you can count on. Service you can trust.

Please Don't Handwrite!
Download this PDF file and type in the data fields before printing. You can save your data in the PDF file.

AAH Prior Authorization Request

Fax: (855) 891-7174 **Telephone:** (510) 747-4540

Note: All fields that are **BOLDED** are required.

Authorizations are based on medical necessity and covered services. Authorizations are contingent upon member's eligibility and are not a guarantee of payment. The provider is responsible for verifying member's eligibility on the date of service.

Member must be eligible on date of service and procedure must be a covered benefit. REMAINING BALANCE MAY NOT BE BILLED TO THE PATIENT. If interested in becoming an AAH contracted provider, contact Provider Services at (510) 747-4510. Please verify eligibility using one of the following methods:

1. Web: https://www.alamedaalliance.org
2. AAH Customer Service: (510) 747-4567

TYPE OF REQUEST (please check only one):

- ☐ **Routine** Approval based on AAH review. AAH has up to 5 business days to process routine requests.
- ☐ **Urgent** Inappropriate use will be monitored. AAH has up to 72 hours to process urgent requests for all lines of business.
- ☐ **Retro** Only granted for member eligibility issues on DOS or for services rendered in emergent or urgent situation. AAH has up to 30 calendar days to process retro requests.
- ☐ **Modification** Request for existing authorized services. Please enter the AAH Auth Number and the Member information below. Use a separate sheet to specify your changes or to attach additional supporting documentation.

If Mod, AAH AUTH #:

REQUESTING PROVIDER

Name:
Address:
City: State: Zip:
Requesting Provider NPI #:
Office Contact:
Phone: Fax:
Email:

MEMBER (For newborn services provide mother's information and check newborn fields below)

First Name:	Health Plan ID#:
Last Name:	Newborn DOB:
Date of Birth:	Phone:
Address:	Other Insurance (i.e. Commercial, Medicare A, B):
City: State: Zip:	

RENDERING PROVIDER/FACILITY

Name/Facility:		Phone:
Specialty/Dept:		Fax:
Provider NPI #:	Provider TIN#:	Address:
Facility NPI #:	Facility TIN#	City: State: Zip:

Place of Service (Check one-please do not circle)

- ☐ Inpatient Hospital
- ☐ Outpatient Clinic
- ☐ Outpatient Hospital
- ☐ Ambulatory Surgical Center
- ☐ Provider's Office
- ☐ Home

- ☐ **Non-Contracted.** Provide reason for out of network request
- ☐ **Elective Inpatient.** Estimated admission date:
- **Anticipated Date of Service:**

DIAGNOSES / SERVICE CODES **Please DO NOT describe the procedures; only enter the Code, Modifier, and Quantity.**

Diagnosis Code(s):									

CPT/HCPCS	Mod	Qty	CPT/HCPCS	Mod	Qty	CPT/HCPCS	Mod	Qty	CPT/HCPCS	Mod	Qty

 Revised: 01/26/2016