IMPORTANT: Incomplete forms will be faxed back to sender.

SHARP Health Plan

OFFICE USE ONLY
Eligibility verified:
☐ Yes ☐ No

Prior Authorization/Precertification Form

Health Maintenance Organization (HMO) Plan, Point of Service (POS) Plan and Preferred Provider Organization (PPO) Plan

Purpose

The purpose of this form is to request a referral, prior authorization or precertification for a Sharp Health Plan member, whether enrolled in HMO, PPO or POS plans, to receive health services, including those from an out-of-network provider.

Instructions

- Please validate member eligibility and benefits prior to rendering services.
- Attach all applicable clinical documentation, such as progress notes, labs or radiology.

Submit

Please fax your finished form and required documents to:

Attention: Medical Management
1-619-740-8111

Payment for services is dependent upon the member's eligibility at the time services are rendered. Copays, coinsurance and/or deductibles may apply. Precertifications are valid for the date range specified on the approval letter.

Need help? Call Customer Care at 1-800-359-2002 or email customer.service@sharp.com.
We're available to assist you Monday through Friday, 8 a.m. to 6 p.m.

Member Information

Please check one: ☐ HMO ☐ POS ☐ PPO

First name:	Last name:	Middle initial:
ID#:	Phone number:	Birth date (MM/DD/YY):
Home address:		
City:	State:	ZIP code:

Requesting Provider Information

Name:	Phone number:	Fax number:
Address:		
City:	State:	ZIP code:

NPI#:	Member requested? ☐ Yes ☐ No	☐ Inpatient ☐ Outpatient	Prepared by:	Date sent (MM/DD/YY):

☐ **Routine/standard request:** Decisions will be rendered within five business days from receipt of all necessary information.

☐ **Urgent request:** Decisions will be rendered within 72 hours from receipt of all necessary information. A request is urgent if waiting five days would seriously jeopardize the member's life, health or ability to regain maximum function or, in their doctor's opinion, subject the member to severe pain that cannot be adequately managed without the care or treatment that is being requested.

Servicing Provider/Facility Information

Name:	Phone number:	Fax number:
Address:		
City:	State:	ZIP code:

Tax ID:	NPI#:	Expected date of service (MM/DD/YY):	Inpatient length of stay:

Servicing Provider/Facility Information, Continued				
Diagnosis	**ICD-10 Code**	**Procedure and Equipment**	**Procedure Code**	**Units**

Reason for request (Please submit all pertinent documentation with request.):

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002. IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.