Prior Authorization (PA) Request Form – Adult Palliative Care

The Alameda Alliance for Health (Alliance) Prior Authorization Request Form – Adult Palliative Care is confidential. Please use this form to request prior authorization for all Alliance lines of business (i.e., Medi-Cal, Group Care, and Alameda Alliance Wellness (HMO D-SNP)). Authorizations are based on medical necessity and covered services. Authorizations are contingent upon the member's eligibility and are not a guarantee of payment. The provider is responsible for verifying the member's eligibility on the date of service. The Alliance member must be eligible on the date of service, and the procedure must be a covered benefit. The remaining balance may not be billed to the patient.

If you are interested in joining the Alliance network, please call the Alliance Provider Services Department at **1.510.747.4510**. The easiest and fastest way to verify eligibility is through the Alliance Provider Portal. To log in or create an account, visit the Alliance website at **www.alamedaalliance.org** and click on the Provider Portal button in the top right corner, and you will be redirected to our Provider Portal. If you are creating an account, please allow two (2) business days for the Alliance Provider Service Department to review and respond.

INSTRUCTIONS

1. Only type responses in all the fields below. Do not handwrite or stamp.
2. All fields marked with (*) are required.
3. Print and fax the completed typed form to the Alliance Utilization Management (UM) Department at **1.855.891.7174**.

Please Note: Handwritten or incomplete forms may be delayed. If you have any questions, please call the Alliance UM Department at **1.510.747.4540**.

☐ ***Clinicals are required to be submitted with this form. Please check this box to certify that clinicals have been attached.**

Section 1: Requesting Provider Information

Facility Name: East Bay Pulmonology Group

*Last Name: Green *First Name: Robert

*Address: _____

*City: _____ *State: _____ *Zip Code: _____

*NPI Number: 1,122,334,455 *Tax ID Number: _____

Office Contact Person Full Name: _____

*Phone Number: _____ *Fax Number: _____

*Email: _____

Section 2: Type of Request

*Please select only one (1):

- ☐ **Retro** – Granted for eligibility issues or urgent care. Requests must be within 90 days of the date of service. Processing time is up to 30 calendar days from receipt.
- ■ **Routine** – Based on Alliance clinical review. The Alliance has up to seven (7) calendar days to process routine requests for all lines of business.
- ■ **Standing Referral** – The Alliance has up to three (3) business days to process requests for standing referrals.
- ☐ **Urgent** – Defined as a request for medical services that needs prompt decision because a member's condition presents as an imminent and serious threat to the member's health, such as potential loss of life, limb, or a major bodily function. Inappropriate use will be monitored. The Alliance has up to 72 hours to process urgent requests for all lines of business.
- ☐ **Authorization Change Request** – Request for existing authorized services. Please enter the Alliance authorization number and the member information below. Use a separate sheet to specify your changes or to attach additional supporting documentation.

*If **Authorization Change Request**, please provide the Alliance Authorization Number: _____

Section 3: Member Information

For newborn services, provide the mother's information.

*Last Name: Smith *First Name: Jane

*Date Of Birth (MM/DD/YYYY): 10/15/1958

*Alliance Member ID Number: A123456789 *Client Index Number (CIN): _____

Medicare Beneficiary Identifier (MBI): _____

*Address: 456 Oak Avenue

*City: Oakland *State: CA *Zip Code: 94612

Phone Number: _____

Other Insurance (please select all that apply, and include the name of your insurance):

- ☐ Commercial: _____
- ☐ Medi-Cal: _____
- ☐ Medicare: _____

Section 4: Requested Service

General Eligibility

*Please select only one (1):

- ☐ Patient has documentation of a decline in health status and is not eligible for hospice
- ☐ Patient is eligible for hospice but declines

Member's Qualifying Condition

*Please select all that apply, must meet at least one (1) condition to be eligible:

- ☐ **Congestive Heart Failure (CHF):** Must meet (a) and (b)
  a. The member is hospitalized due to CHF as the primary diagnosis, with no further invasive interventions planned, or meets the criteria for the New York Heart Association's (NYHA) heart failure classification III or higher; and
  b. The member has an ejection fraction of less than 30 percent for systolic failure or significant co-morbidities.
- ■ **Chronic Obstructive Pulmonary Disease (COPD):** Must meet (a) or (b)
  a. The member has a forced expiratory volume (FEV) of one (1) less than 35% of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
  b. The member has a 24-hour oxygen requirement of greater than or equal to three (3) liters per minute.
- ☐ **Advanced Cancer:** Must meet (a) and (b)
  a. The member has stage III or IV solid organ cancer, lymphoma, or leukemia; and
  b. The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two (2) lines of standard of care therapy (chemotherapy or radiation therapy).
- ☐ **Liver Disease:** Must meet (a) and (b) combined or (c) alone
  a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, and an international normalized ratio greater than 1.3, and
  b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
  c. The member has evidence of irreversible liver damage and has a Model for End-Stage Liver Disease (MELD) score greater than 19.
- ☐ **Advanced Dementia/Alzheimer's Dementia:** Must meet four (4) out of five (5) criteria (profound memory deficits, functional impairment (ADL dependencies), minimal communication, decreased oral intake, and/or significant weight loss in the last six (6) months, malnutrition).

Section 5: Rendering/Servicing Provider Information

*Last Name: _____ *First Name: _____

Specialty: Palliative Care

*Address: _____

*City: _____ *State: _____ *Zip Code: _____

*NPI Number: 9988776655 *Tax ID Number: _____

*Phone Number: _____ *Fax Number: _____

*Starting Service Date: 06/08/2026 Ending Service Date (if known): _____

*Place of Service (please select only one (1)):

- ☐ Office (11)
- ☐ Home (12)
- ☐ Assisted Living (13)
- ☐ Group Home (14)
- ☐ Inpatient Hospital (21)
- ☐ Outpatient Hospital (22)
- ☐ Nursing Facility (32)
- ☐ Custodial Care Facility (33)
- ☐ ICF/DD (54)
- ☐ Other (99): _____

Section 6: Out-of-Network Information

*Is the service being requested out-of-network: ☐ Yes ☐ No

If **Yes**, provide the reason for out-of-network facility/provider (please select only one (1)):

- ☐ In-network provider not accepting new patients
- ☐ In-network provider not available
- ☐ Patient request
- ☐ Specialized procedure/Area of expertise
- ☐ Timely access to provider
- ☐ Other: _____

Section 7: Discharge Planning Information

*Is the service needed for discharge planning: ☐ Yes ☐ No

If **Yes**, what is the discharge date (MM/DD/YYYY)? _____

Section 8: Diagnoses/Service Codes
At least one (1) diagnosis code is required.

*ICD Code(s)	Primary (Check only if **yes**)	ICD Code(s)	Primary (Check only if **yes**)
J44.9	■	R06.02	☐
G89.4	☐		☐
	☐		☐
	☐		☐

*Code CPT/HCPCS	*Description	Modifier 1	Modifier 2	Quantity	Unit Type	Total Billable Units
99245	Initial Consultation					
99378	Medical team conference					