Authorization Request Form

ASPIRE HEALTH PLAN
10 Ragsdale Dr., Ste. 101, Monterey, CA 93940
(855) 570-1600 Phone
831-657-2669 Fax

Request Date	Sender's Name	Sender's Phone Number	Sender's Fax Number

Provider Information

PCP (If Applicable)	Referring Physician's Name	Requested Provider's Name

Patient Identification

Last Name		First Name	
Address		City	State
Phone Number	Date of Birth	ID Number	

Requested Service / Procedure / Location

Service Type

☐ Office ☐ Outpatient ☐ Inpatient (Anticipated LOS _____)

Facility Name (Procedure Location) ☐ In-Network ☐ Out-of-Network

Procedure Date (Please provide "tentative" date if procedure not yet scheduled)

Diagnosis Description

Diagnosis Codes				

Service / Procedure Description

CPT / HCPCS Codes				

Occupational, Physical and Speech Therapy Requests Only

Number of Visits Requested	Date of Initial Onset	Date of Initial Visit

Note: This authorization is exclusive of Out-of-Network and/or Non-Contracted facility or provider, unless specifically so authorized.

In order to process your request as quickly as possible, clinical information (chart notes, diagnostic studies, etc.) must be included with this request. For physical medicine requests, include a copy of the initial evaluation, treatment plan, legible progress notes and documentation of compliance with the prescribed home exercise program.

Version 20151001