AUTHORIZATION REQUEST FORM

Clinical Review Request for Aspire Health Plan Members

All supporting clinical rationale and documentation MUST BE submitted for timely review. Requests can be submitted via fax, or for real-time updates, use the Provider Portal at: **https://id.ayin.com**

10 Ragsdale Dr., Ste. 101, Monterey, CA 93940
(831) 657-0700 Phone
(831) 657-2669 Fax

REQUEST INFORMATION		
Request Date:	Request Type: ☐ Pre-Service Review ☐ Post-Service Review	
Rationale for Urgent / Expedited Review (only applies when standard timeframe may seriously endanger the member's LIFE, HEALTH, or ABILITY TO REGAIN MAXIMUM FUNCTION. Procedure scheduling is NOT a valid reason to expedite. Expedited requests will not be processed as such unless appropriate rationale is provided):		
Requestor's Name:	Requestor Phone #:	**Fax # for Determination Notification:**

PATIENT INFORMATION	
Patient Name:	DOB:
Member ID #:	Member Phone #:
Street Address :	City, State, Zip:

PROVIDER INFORMATION		
Ordering Provider/Prescriber Name:	Ordering Provider/Prescriber NPI:	Ordering Provider/Prescriber Phone #:
Administering Provider/Facility Name:	Administering Provider/Facility NPI:	
Provider Status: ☐ In-Network ☐ Out-of-Network ☐ Out-of-Area (outside of Monterey County) **For Out-of-Network / Out-of-Area**, state reason in-network or local provider is unable to provide care or administer drug:		

SERVICE / PROCEDURE / DRUG INFORMATION	
Diagnosis / ICD-10 code(s):	Diagnosis Description:
Procedure Codes (PCPCS/CPT/J Codes – include quantity i.e. A4604 x 3):	
For Physician-Administered Drug Requests, additional information below MUST be completed for timely processing	

ADDITIONAL INFORMATION REQUIRED			
Physician-Administered Drug Request Additional Information			
Site of Service: ☐ Provider's Office ☐ Specialty Clinic ☐ Outpatient Hospital ☐ Surgery Center ☐ Home Infusion ☐ Home Health Agency ☐ DME Provider ☐ Other:			
New Drug Therapy: ☐ Yes ☐ No; continuation of therapy request Date of initial therapy:		Drug Name:	
Dose:	Route of Administration:	Drug NDC:	
Frequency:	Duration of Therapy:	Height: ☐ Ft. ☐ In. Weight: ☐ ◯ kg ◉ lbs	
Patient Drug Allergies:			
Provide clinical rationale for override or exception request. List names and doses of previous medication(s) tried and failed. Please provide all relevant clinical criteria and supporting documentation with this completed form.			

Medication / HCPCS Code(s)	Dose	Visits / Frequency	Length of Treatment