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Prior Authorization Request Form



CCPP Fax Numbers

Routine: (559) 551-3659
 Inpatient: (559) 551-3670
 Urgent: (559) 551-3664

REFERRAL REQUESTED DATE: _____

ROUTINE
(5 days)

URGENT
(72 hours)

RETRO
(30 days)

STANDING
(30 days)

DATE OF SERVICE: _____

FORM WILL BE RETURNED IF THE MEMBER'S NAME, ID #, HEALTH PLAN, OR CLINICAL INFORMATION IS INCOMPLETE OR ILLEGIBLE.

PATIENT INFORMATION

Patient Last Name:		First Name:		Middle:
DOB:	Age:	Gender: M F	Phone:	
Address:		City:	Zip:	
Health Plan:		Member ID:	Member Effective Date:	
PCP:	Phone:		Fax:	

REFERRING PROVIDER INFORMATION

Referring Provider Name:	Office Contact Name:
Phone:	Fax:

REFERRED TO PROVIDER INFORMATION

Referred To Provider Name:	Specialty:		
Phone:	Fax:		
REQUESTED FACILITY:			
Place of Service:	Office (11)	Inpatient Hospital (21)	Outpatient Hospital (22)

REQUESTED SERVICES/TREATMENTS

PATIENT REQUEST		M.D. REQUEST	
Primary ICD-10 Code:	Description:	Secondary ICD-10 Code(s):	
CPT Code:	Qty:	Description:	
CPT Code:	Qty:	Description:	
CPT Code:	Qty:	Description:	
CPT Code:	Qty:	Description:	
CPT Code:	Qty:	Description:	
Clinical Problem & Duration:			
Pertinent Clinical History / Lab / X-Ray:			
Treatment tried/failed:			
Why is this referral or procedure necessary?			
PHYSICIAN SIGNATURE			DATE:

STATEMENT FOR PROVIDER: Further care must be authorized before it is rendered. If additional treatment is required, contact the referring physician. Additionally, the consultant's findings and recommendations must be sent to the referring physician. Authorization does not guarantee payments: All claims are subject to eligibility, contracted provisions, and exclusions. This certificate is valid for 60 days from the approval day. All lab work and imaging studies should be done at an Astrana Health contracted facility. UM decisions are based on standardized criteria. Providers may view criteria upon request. Call 626-282-0288 for more information.

Effective Date 12/01/2024