CalOptima Better. Together.

REQUEST FOR LETTER OF AGREEMENT

CalOptima UM Department Fax: 714-796-6654

(Sections 1 through 4 must be fully completed in order for request to be processed. Incomplete requests will be returned.)

SECTION 1

Contact Submitting LOA Request

Date Submitting Request To CalOptima:

Health Network Contact Submitting LOA Request (first and last name):

Health Network Contact Phone #: Fax #:

Health Network Contact Email Address:

SECTION 2

Member

Last Name: First Name: Middle Initial:

CIN #: DOB:

Line of Business: ☐Medi-Cal ☐OneCare Connect ☐OneCare

Health Network:

SECTION 3

Provider of Service

Facility: ☐Hospital ☐ASC ☐SNF (short stay) ☐Dialysis Center

☐Professional (e.g., Neurology, Urology, Oral Surgery) Specialty:

☐Ancillary (e.g., DME, Home Health Agency, Transportation) Type:

☐Other provider type not listed above:

Provider Name: Provider NPI:

Provider Address:

Provider Contact Information for LOA: Name: Title:

Telephone #: Fax #:

SECTION 4

Services

Health Network Authorization # (s): Place Of Service: ☐Outpatient ☐Inpatient
(Attach copy of authorization)

Authorization Start Date: Authorization End Date:

Expected DOS Beginning (prospective admit):

Description of Authorized Service(s) including CPT/HCPCS Codes # of units:

Reason for Referral/Comments:

☐Continuity of Care

SECTION 5 (CalOptima use only)

For CalOptima Internal Use Only

Approved By CalOptima Medical Director: Date:

Approved By CalOptima Director of Contracting (or designee): Date: