CalOptima
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DEFERRAL EXTENSION NOTIFICATION FORM

RESULTS OF AUTHORIZATION REQUEST REVIEW: DEFERRAL

CalOptima's LTC Authorization Unit must receive the additional medical information requested on this deferred Authorization Request Form (ARF) by ___________________ ___________________.

We will review the medical information and authorization request and will process it at the next scheduled on-site visit.

If you are not able to provide the additional information by the above date and would like an extension deferral period, please so indicate to the CalOptima LTC Authorization Unit at any time up to the date specified above. You may do so by completing the information below and faxing it to **714-246-8843** or emailing to ltcauthorization@caloptima.org. Thank you for your cooperation.

REQUEST FOR EXTENSION OF DEADLINE TO SUBMIT MEDICAL INFORMATION ON A DEFERRED ARF

Provider Name	**Provider Address**
CalOptima Member Name	**Member Address**
CalOptima Member ID Number	**ARF Control Number**

Services for authorization requested

Reason extension requested

Estimated date information will be submitted (Extensions granted in 14-day increments.)

Provider Signature	**Date**