CalOptima
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Date Stamp

Retro Authorization Request for Acute Inpatient Care

Facility Name:____________________________ Phone:____________________________

Contact Name:____________________________ Fax:______________________________

Billing Service Name:______________________ Provider No. (UB92 Box 51)___________

Retro Eligibility: ☐ (Member was not eligible at time of service – Retroactive eligibility now established)
Late Request: ☐ (Member was eligible at time of service – Prior Auth was not obtained)

Name:___________________ Admit Date:_____________ Service Begin Date:________
CIN# Discharge Date: Service End Date:
DOB: MR/Account:
Newborn Care must indicate: Mothers SSN/CIN:_________ DOB:________ Insurance:_____________

Comments:____
____
____

Attach this form to the following **Required Documents:**

☐ Admission Face Sheet
☐ Itemized Statement
☐ History & Physical Examination
If applicable
☐ Emergency Department Report
☐CCS Authorization/Denial
☐Submit evidence that member has no Medicare A benefit
(Copy of printout from Medicare common working file)
☐ Discharge Summary ☐ Coding sheet
☐ Progress Notes ☐ Physician Orders
☐ Medi-Cal Eligibility Print Out for Date of Service
☐ Operative/Procedure Report(s)
☐ Tertiary Reimbursement Documentation/DRG
☐ Primary Insurance EOB/Denial

DO NOT WRITE BELOW THIS LINE FOR CalOptima USE ONLY

☐ COD Eligibility ___/___/___ Start Date:__________ End Date:__________ Aid Code:__________
☐ COD Eligibility ___/___/___ Start Date:__________ End Date:__________ Aid Code:__________
☐ Health Plan______________ Start Date:__________ End Date:__________
☐ Possible CCS eligible condition – Request Authorization from and submit claim to CCS – CCS#____________

From Through		Requested		Approved	
Date Date		Days	Bed Type Day	s	Bed Type

Comments:____
____
____

☐ Level of care may qualify for tertiary reimbursement. Mail request for tertiary reimbursement:
- Attach DRG coding sheet or equivalent to request form.

☐ Does not meet OC EMSA P&P Trauma Triage Guidelines for Critical Trauma Victim (CTV)

Authorization Reference No.

If you disagree with this determination, you may request reconsideration of this decision by submitting an Appeal to: CalOptima, Attention: Care Coordination Department, P.O. Box 11033, Orange, California 92856. The appeal must be in writing and: (1) be received within 60 calendar days from the date of this Care Coordination Department decision; (2) include a letter and/or document to justify reconsideration; and (3) be clearly labeled "UM Appeal."

Updated: 12/29/05