SCAN Referral / Authorization Request Form

Please complete and Fax to: 800-411-0671

DO NOT SCHEDULE SERVICE UNTIL AFTER REQUEST IS APPROVED

Type of Request for Authorization: Routine ☐ Continued/Recertification ☐

Member Information			
Member Name	Member ID#		DOB
Address	City	State	Zip
Daytime Phone			
Health Plan Code	Medi-Cal - SNP Plan		

Ordering Provider/Physician and Contact # Phone/Fax

Requested/Servicing Provider and Contact # Phone/Fax

Requested CPT/HCPC Code(s)--list all that apply for items/services requested:

Diagnosis/ICD 10:

Clinical Justification/Medical Necessity for Item/Service:

Attach any clinical records, documentation to support request to this form.

Claims Address:
SCAN Health Plan
P.O. Box 22698
Long Beach, CA 90801-5616

SIGNATURE REQUIRED FOR COMPLETION OF REQUEST

Signature:_______________________________________ Date:____________________

Print Name:_____________________________

- Prior Authorization for services is required before services are rendered.
- Both Expedited and Standard Requests will be handled according to regulatory guidelines and timeframes.
- SCAN Health Plan will respond within the required CMS time frames for the processing of Organizational Determinations

Questions, or to check status of authorization please call (888) 540-7226

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