Community Supports – Authorization Request Form

The Alameda Alliance for Health (Alliance) Community Supports Authorization Request Form is confidential. Please use this form to request authorization for Alliance Medi-Cal and Alameda Alliance Wellness (HMO D-SNP) members. Authorizations are based on the appropriateness of the service being requested. Authorizations are contingent upon the member's eligibility and are not a guarantee of payment. The provider is responsible for verifying the member's eligibility on the date of service.

If you are interested in joining the Alliance network, please call the Alliance Provider Services Department at **1.510.747.4510**. The easiest and fastest way to verify eligibility is through the Alliance Provider Portal. To log in or create an account, visit the Alliance website at **www.alamedaalliance.org** and click on the Provider Portal button in the top right corner, and you will be redirected to our Provider Portal. If you are creating an account, please allow two (2) business days for the Alliance Provider Service Department to review and respond.

INSTRUCTIONS

1. Please print clearly or type in all the fields below.
2. Attach a clinical summary and/or supporting documentation (i.e., clinic notes, hospital discharge summary, etc.) for the requested Community Support.
3. Please fax or email the completed form to the Alliance Community Supports Department at **1.510.995.3726** or **CSDept@alamedaalliance.org**.

Please Note: Handwritten or incomplete forms may be delayed. Forms submitted without supporting information may also be delayed. If you have any questions, please call the Alliance Community Supports Department at **1.510.747.4545**.

☐ **Clinicals are required to be submitted with this form. Please check this box to certify that clinicals have been attached.**

Section 1: Requesting Provider Information

Last Name: ______________________ First Name: ______________________

Address: ____

City: ______________________ State: __________ Zip Code: __________

NPI Number: ______________________ Tax ID Number (TIN): ______________________

Office Contact Person Full Name: ______________________________

Phone Number: ______________________ Fax Number: ______________________

Email: ____

Date of Request: ____

Service Start Date: ______________________ Service End Date: ______________________

Section 2: Member Information

Last Name: ______________________________ First Name: ______________________________

Date Of Birth (MM/DD/YYYY): ____

Alliance Member ID Number: ______________ Client Index Number (CIN): ________________

Medicare Beneficiary Identifier (MBI): ____

Address: ____

City: ____________________________________ State: ____________ Zip Code: _____________

Phone Number: __________________________ ☐ Home ☐ Cell

Primary Diagnosis (including ICD-10 code(s)): ____

Is the member currently linked to a case management (ECM/CM) team? ☐ Yes ☐ No

Case Manager/ECM Name: ____

Case Manager/ECM Phone Number: ____

Section 3: Servicing Provider Information

Last Name: ______________________________ First Name: ______________________________

Address: ____

City: ____________________________________ State: ____________ Zip Code: _____________

NPI Number: ____________________________ Tax ID Number (TIN): ______________________

Phone Number: ___________________________ Fax Number: _____________________________

Email: ____

Section 4: Requested Service(s)

Type of Request

Please select only one (1):

☐ Initial Request

☐ Extension Request

Previous Authorization Number: ____

Section 4: Requested Service(s) (cont.)

Please select all that apply:

Assisted Living Facility (ALF) Transitions

- [ ] T2038 (U4)
- [ ] H2022 (U5)

Asthma Remediation

- [ ] S5165

Units/Description: ______________________________

Community or Home Transition Services

- [ ] T2308 (U5)

Environmental Accessibility Adaptations (Home Modifications)

- [ ] S5165 (U6)
- [ ] S5161 (U6) – PERs

Housing Deposit

- [ ] H0044 (U2)

Housing Tenancy and Sustaining Services

- [ ] T2040 (U6) – Financial management
- [ ] T2041 (U6) – Brokerage support

Housing Transition Navigation Services

- [ ] H0043 (U6)
- [ ] H2016 (U6)

Medically Tailored Meals (MTM)/Medically Supportive Food (MSF)

Meal Frequency Request

- [ ] S5170 (U6) – One (1) meal per day
- [ ] S5170 (U6) – Two (2) meals per day

Medically Supportive Food

- [ ] S9470 (U6) – One (1) grocery box per week
- [ ] S9977 (U6) – Nutritional Counseling (included when paired with direct food assistance)

Personal Care and Homemaker Services (PCHS)

- [ ] T1019 (U6)

Hours: ______________________________

- [ ] S5130 (U6) – Members older than 18 years of age

Hours: ______________________________

Section 4: Requested Service(s) (cont.)

Recuperative Care (Medical Respite)

- ☐ T2033 (U6)

Respite Services

- ☐ S9125 (U6) – In the Home
- ☐ H0045 (U6) – Not in Home
- ☐ S5151 (U6) – Unskilled

Transitional Rent

- ☐ H0043 (U2) – Interim
- ☐ H0044 (U6) – Permanent

Section 5: Patient's Medical Necessity

Please describe and attach all supporting documentation to the form: