Scripps | Health Plan Services

Authorization Change Request Form

Effective 6/13/2016, the attached Change Request form is for Scripps Clinic Medical Group and Scripps Coastal Medical Group authorizations only.

This form is only to be used upon receipt of an approved authorization from the groups mentioned above. If you do not currently have an approved authorization, please use the correct Scripps Health Plan Services (SHPS) Authorization Request Form.

All fields are required for changes to be reviewed. Forms that are incomplete will not be processed. All Authorization Change Requests will follow the steps below:

1. Fill out the Authorization Change Request form entirely.
2. Fax the form back to SHPS Utilization Management (UM) Department.
3. SHPS UM will review the request for changes.
4. SHPS UM will request necessary clinical documentation (if applicable).
5. SHPS UM will respond back via fax with Approval/Denial of the changes.

The turnaround time for these requests is 10 business days from the date received.

Please Note: Services are **not** covered until you have final confirmation that the changes being requested are approved. Authorized services are not a guarantee of coverage. Member eligibility must be verified with each health plan prior to rendering services.

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CHANGE ONLY

DATE OF REQUEST: _____

Authorization Change Request Form

Patient Identification:

Name: _____

Health Plan: _____

MRN: _____

DOB: _____

Approved Authorization #: _____

Requesting MD: _____

Contact Name (at requesting office): _____

Requestor's Phone #: ( ) _____

Fax #: ( ) _____

FAX TO: Change Line (858) 964-3138

Service Change Being Requested:

Check One

( ) Code Changes
( ) Date Extension
( ) Location Change
( ) Provider Change
( ) Retro Date Extension
( ) Unit Change
( ) Other (specify)

Provider Name: _____

Facility: _____

Appointment Date: _____

Diagnosis: 1) _____ ICD-10 Code _____
2) _____ ICD-10 Code _____

Description 1) _____ CPT Code _____
2) _____ CPT Code _____

Reason for Change Request:

FOR INTERNAL SHPS UM DEPARTMENT USE ONLY		
Status of Change Requested		
Approved	Date:	By:
Denied	Date:	By:
Request More Information	Date:	By: