



Accreditation of Medi-Cal and L.A. Care Covered



L.A. Care HEALTH PLAN®

Accessing Breast Pumps for L.A. Care Members

Submit a pre authorization form to L.A. Care's Utilization Management Department:
<http://www.lacare.org/providers/provider-resources/provider-forms>

L.A. CARE HEALTH PLAN PRE-AUTHORIZATION REQUEST FORM
If the treating physician would like to discuss this case with the physician or health care professional reviewer or obtain a copy of the criteria used to make this decision, please call 1-877-431-2273.

Please fax completed form to L.A. Care UM Department:

Medi-Cal Auth. for Prior Fax: (213) 438-5777 Health Integrated Fax: (877) 872-3161
 Medi-Cal Urgent Fax: (213) 438-6100 Transplant Fax: (213) 438-5071
 Medi-Cal for Concurrent Right Fax: (877) 314-4957 Case Management Fax: (213) 438-5034
 Medicare Fax: (213) 438-5085 COC Fax: (855) 351-9262

L.A. Care Use Only	
UM Database Log ID#:	
Provider Status:	<input type="checkbox"/> In-network <input type="checkbox"/> Out-of-network
Member Language:	

DATE:	PCP:	PPG:
LINE OF BUSINESS (check one): <input type="checkbox"/> MCLA <input type="checkbox"/> L.A. Care Covered <input type="checkbox"/> Cal MediConnect <input type="checkbox"/> Medicare dSNP <input type="checkbox"/> PASC-SEIU <input type="checkbox"/> Healthy Kids		
PATIENT INFORMATION		
MEMBER NAME:	DOB:	MEMBER ID#:
ADDRESS:		PHONE NUMBER:
SERVICE IS (check one): <input type="checkbox"/> URGENT (Within 72 hours) <input type="checkbox"/> ROUTINE (Within 5 calendar days) <input type="checkbox"/> Post Service (Within 30 calendar days)		Preferred Language:
REFERRAL - SERVICE TYPE REQUESTED		
<input checked="" type="checkbox"/> DME (Expected Duration): _____	<input type="checkbox"/> Major Diagnostic Procedure / Radiology	<input type="checkbox"/> SNP
<input type="checkbox"/> Home Health	<input type="checkbox"/> OB Care EDC: _____	<input type="checkbox"/> Specialist Consult / Treatment / Follow-Up Care
<input type="checkbox"/> Hospice	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Surgical Procedure
<input type="checkbox"/> Inpatient	<input type="checkbox"/> Second Opinions	<input type="checkbox"/> Other: _____
PROVIDER SUBMITTING THIS REQUEST		
REQUESTING PROVIDER NAME:	SPECIALTY:	PHONE NUMBER:
ADDRESS:		FAX NUMBER:

- Breast Pumps requested under codes **E0602**, **E0603** are always approved automatically.
- An approval letter is sent via fax to the requestor (usually the ordering MD) as well as the vendor, Medical Group, and PCP (if different from the ordering MD).
- Upon receipt of the authorization letter the vendor contacts the member to arrange for delivery of the pump/approved items.
- To check the status, or to find out who has been assigned to provide the approved items to her, e.g., the DME company, the member can call UM to inquire. The LA Care staff handling the call will tell them who would be providing the DME and how to contact them.

Health Education materials for members can also be ordered through L.A. Care's website: <http://www.lacare.org/providers/provider-resources/health-education-tools>

Questions? Contact Lenna Monte, Health Education Manager lmonte@lacare.org