Optum Rx®

Please fax completed form to **1-844-403-1024**

Date Sent:	
To:	Optum Rx Prior Authorization Department
Fax:	1-844-403-1024
Phone:	1-800-711-4555
Re:	California Delegated Medical Group Auto-Authorization

From:

Phone:

Fax:

Number of pages, including cover sheet:

Please have the doctor or a qualified member of the office staff complete the next page(s) and fax the completed form to 1-844-403-1024.

If you have questions or want to speak with an Optum Rx Prior Authorization Advocate, call 1-800-711-4555.

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California Delegated Medical Group Auto-Authorization Form

Medical Group Information (required)	
Medical Group Name:	
Medical Group Authorization ID:	
Authorization Start Date:	**Authorization End Date:**

Provider Information (required)			Member Information (required)		
Provider Name:			**Member Name:**		
NPI#:			**Insurance ID#:**		
Office Phone:			**Date of Birth:**		
Office Fax:			**Phone:**		
Office Street Address:			**Street Address:**		
City:	**State:**	**Zip:**	**City:**	**State:**	**Zip:**

Medication Information (required)	
Medication 1	
Medication Name:	**Prescription attached? (Circle one) Yes / No**
Strength:	**Dosage Form:**
Medication 2 *(if applicable)*	
Medication Name:	**Prescription attached? (Circle one) Yes / No**
Strength:	**Dosage Form:**
Medication 3 *(if applicable)*	
Medication Name:	**Prescription attached? (Circle one) Yes / No**
Strength:	**Dosage Form:**
Medication 4 *(if applicable)*	
Medication Name:	**Prescription attached? (Circle one) Yes / No**
Strength:	**Dosage Form:**
Medication 5 *(if applicable)*	
Medication Name:	**Prescription attached? (Circle one) Yes / No**
Strength:	**Dosage Form:**

Special Notes

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