

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.

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)	
<i>Medication 1</i>	
Medication Name:	Prescription attached? (Circle one) Yes / No
Strength:	Dosage Form:
<i>Medication 2 (if applicable)</i>	
Medication Name:	Prescription attached? (Circle one) Yes / No
Strength:	Dosage Form:
<i>Medication 3 (if applicable)</i>	
Medication Name:	Prescription attached? (Circle one) Yes / No
Strength:	Dosage Form:
<i>Medication 4 (if applicable)</i>	
Medication Name:	Prescription attached? (Circle one) Yes / No
Strength:	Dosage Form:
<i>Medication 5 (if applicable)</i>	
Medication Name:	Prescription attached? (Circle one) Yes / No
Strength:	Dosage Form:

Special Notes

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