LOA REQUEST FORM

For LOA inquiries, please fill out the following LOA REQUEST FORM (Basic Information) in its entirety.

- Please return via email only to contracting@health.uci.edu. Please note that faxes are not accepted.
- All areas are required. For questions, please send email to contracting@health.uci.edu.

Required Information

1. Who is the primary point of contact for this LOA (Name, Ph#, Email):
2. Where should LOA be sent (to what email address)?:
3. Member Name:
4. Member DOB:
5. Member ID #:
6. Health Plan (if applicable):
7. Medical Group (if applicable):
8. Line of Business: Medi-Cal, Medicare (direct or managed), Commercial, Correctional, Worker's Compensation:
    a. For Worker's Compensation, please answer the following:
        i. Name of Employer:
        ii. Claim Number:
9. Authorization # (if applicable):
10. Specialty for the services needed (i.e. Ortho, Urology, ENT, Ophthalmology, etc.)
11. **Who (Entity) at risk for the professional component**:
12. Where to send Claims for Professional billing (Address, phone number, Attn to whom):
13. **(Who) Entity at risk for the facility component:**
14. Where to send Claims for Facility billing (Address, phone number, Attn to whom):

Transfer Section (Complete Only if applicable)

Please fill out the following if your request is regarding a Transfer LOA:

1. UCI Physician/Department Requested:
2. Transfer Type:
3. Date of Service:
4. Transferring Hospital:
5. Transferring Hospital Point of contact (Name, ph #, email):
6. Will the patient be transferred back to the original hospital?
7. Is the transferring hospital discharging the patient?
8. Notes:

Please include the email address of a staff member at the transferring hospital who has the authority to enter into a financial agreement.