UCI Health

LOA REQUEST FORM
(THIS IS NOT A LETTER OF AGREEMENT)

Please complete this form in its entirety

- **This form is to be completed by the Party responsible for payment for services.**
- Completed forms and/or questions, should be sent via email to Contracting@hs.uci.edu
- Please note that **faxes cannot be accepted.**
- Once this form is completed, we will send the LOA via Secure Email or DocuSign for signature.
- **This Form Requires Download** to fill out: After opening Form, go to File (left side of your screen>Save As>Download a Copy)

Services are being requested for the following Facility (Hospital):

☑	UCI Health-Orange	☐	UCI Health-Fountain Valley	☐	UCI Health-Los Alamitos
☐	UCI Health-Lakewood	☐	UCI Health- Placentia Linda		

LOA Primary point of contact

Name		Phone #		Email Address	

LOA Signatory

Name		Title	

Entity at risk for Professional Services

Name		Phone #		Email Address	
Claims Address for Payor of **Prof** Fees					

Entity at risk for Facility Services

Name		Phone #		Email Address	
Claims Address for Payor of **Fac** Fees					

Patient Information

Name		Date of Birth		ID#	

Specialty Requested: **If your specialty is not listed, enter below:**

Choose below

Type of Medical Services Requested:

Choose below

Patient Coverage (as applicable)

Health Plan	UHC	Medical Group	Alliance Desert Physicians	Auth #	

Line of Business *(please select from the following):*

☐		Commercial	☐	Medicare	☐	Unfunded Patient
☐		Correctional	☐	Medi-Cal/Medicaid	☐	Workers' Compensation *

If Worker's Compensation *

Name of WC Carrier (TPA)		Injury Date	
Name of Employer		Claim #	