VENTURA COUNTY
HEALTH CARE PLAN

Retro-Authorization Request Form

(PLEASE PRINT CLEARLY)

Patient Name : ____________________ Date of Birth : __________
(Last) (First)

Subscriber ID / Policy Number : ____________________
(11 Digit Number)

Date of Service(s) Provided : __________

Service(s) Provided : ____________________

Facility /Clinic Name where Services Provided: ____________________
(Include Specific City Location)

Diagnosis : ____________________

ICD-10 Diagnosis Code(s) : ____________________

CPT Code(s) : ____________________

Submitting Physician : __________ Phone # : __________ Date : __________
(MD Requesting Retro-Auth)

Faxed to VCHCP from ____________________ Fax Number __________
Submitting Facility/Clinic Name
(Include Specific City Location)

Faxed to VCHCP by : __________ Total # of pages : _____ Date : __________
(Person faxing request)

*** Medical Records are required for Retro-Authorization review ***

Please Note : The Ventura County Health Care Plan does not consider this request a dispute.
For tracking purposes VCHCP will track this request as a retrospective authorization request only.
VCHCP will respond within 30-days of receiving the request.

Should you have any questions, please do not hesitate to call
VCHCP Medical Management Department at (805) 981-5060
Monday through Friday 8:30a.m. to 4:30p.m.

Please Fax Retro-Authorization Requests to (805) 658-4556

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