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 Service(s) were Provided : _____

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)

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