

AUTHORIZATION SERVICE REQUEST FORM

Please Submit Consult Notes With This Form
Fax # (657) 400-1204

Request Type: Urgent (Expedited) Standard

Date: _____ Authorization #: _____ Chart #: _____

1

Patient Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient ID #: _____ Male Female DOB: _____ Age: _____

Parent/Legal Guardian: _____ Phone #: _____

Referring to: _____ Specialty: _____

2

PCP Name: _____ Phone #: _____ Fax #: _____

ICD-10: _____ CPT/HCPCS: _____

Dx: _____ CPT/HCPCS: _____

_____ CPT/HCPCS: _____

_____ CPT/HCPCS: _____

Service Requested: _____ CPT/HCPCS: _____

_____ ATTACHMENTS:

_____ Lab

_____ X-Ray

_____ Other

For DME, Therapy, HHC Please Provide Duration & Frequency: _____

Physician Signature: _____ Date: _____

Print Name (or Office Stamp): _____ Specialty: _____

Office Contact: _____ Phone #: _____ Fax #: _____

PHYSICIAN RECOMENDATION FOR INPATIENT STAY/OUTPATIENT SUREGERY/PROCEDURES:

INPATIENT OUTPATIENT SERVICES/TEST DIAGNOSTIC SERVICES/TEST

Facility: _____

Anesthesia Required: YES NO Surgery Assistant: YES NO

Admit Date: _____ Time: _____ Estimated Length of Stay: _____

Work Accident Related: YES NO