601 Potrero Grande Drive, Monterey Park, CA 91755
Telephone: (323) 889-6638 UM Direct FAX Line: (323) 889-6577
San Diego Fax Line (323) 889-6506

TREATMENT AUTHORIZATION REQUEST

☐URGENT ☐ ROUTINE ☐ RETROACTIVE

I. PATIENT INFORMATION

PRIMARY LANGUAGE SPOKEN:_ _____
Require Interpreter: ☐ Y ☐ N
☐ American Sign Language

Member Name: _____ DOB: _____ **GENDER** : ☐ F ☐ M

Member Address: _____ City: _____ Zip:_____ Phone: _____

Member ID#: _____ ☐ **Medicare** ☐ **Medi-Cal** ☐ **Healthy Families** ☐ **Commercial**

II. REFER TO INFORMATION

Date of Request: _____ **Provider Name:** _____ **Specialty:**_____

Provider Address: _____ **Phone:** _____ **Fax:**_____

Facility Name: _____ **Phone:**_____**Fax:**_____

III. SERVICE(S) REQUESTED

☐ **Initial Consult** ☐ **FU visit(s)** _____ ☐ **Home Health** ☐ **Social Services** ☐ **DME**

☐ **Inpatient Admission** ☐ **Outpatient procedure(s)** **Other:** _____

Diagnosis: _____ **ICD 9 CODE(S):**

Service(s)/Procedure(s): _____ **CPT 4 CODE(S):**

Reason for Request: _____

Prior Treatment & Results:

Relevant labs/X-Rays, etc: _____

☐**Health Education (Specify):**_____

Requesting Physicians Name (PLEASE PRINT) _____ **PCP Phone: (_____)**

Physician's Signature _____ **FAX: (_____)**

Accident: ☐ YES ☐ NO **Where Occurred:** ☐ Home ☐ Work ☐ Auto ☐ Other

UM Decision Status: ☐ **APPROVED** ☐ **MODIFIED** ☐ **DEFERRED** ☐ **DENIAL**

AUTH #:_____ **Date Approved:** _____ **Date Auth. Expire:** _____

Comments: _____

_____

_____

Reviewer's Name: _____**Signature:**_____ **Date:**_____

CARE 1st USE ONLY: Member Eligibility as of: _____ **PCP Provider ID #:** _____

☐ **IPA RESPONSIBILITY, Date faxed to IPA:** _____

THIS REFERRAL DOES NOT GUARANTEE ELIGIBILITY. CHECK ELIGIBILITY PRIOR TO RENDERING SERVICE.
Payment will NOT be made for unauthorized services. All lab and x-rays must be ordered/performed by contracting providers (contact Care1st Health Plan U.M. Department at above number if unsure). Specialist reports must be sent to PCP promptly.