brand new day

HEALTHCARE YOU CAN FEEL GOOD ABOUT

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: _____

Dx: _____

_____

_____

_____

Service Requested: _____

_____

_____

_____

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

_____

CPT/HCPCS: _____

CPT/HCPCS: _____

CPT/HCPCS: _____

CPT/HCPCS: _____

ATTACHMENTS:

☐ Lab

☐ X-Ray

☐ Other

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