



AUTHORIZATION REQUEST FORM

INTERNAL WORKSHEET **NOT FOR PAYMENT**

c/o MedPOINT Management
P.O. Box 572734, Tarzana CA 91357
Phone: 800-514-6834 ♦ Fax: 818-533-6742

FORM MUST BE FULLY COMPLETED BY PRIMARY CARE PHYSICIAN'S (PCP) OFFICE.
AUTHORIZATION IS VALID FOR 90 DAYS FROM DATE INDICATED BELOW

☐ STAT

☐ URGENT

☐ PATIENT REQUEST

☐ ROUTINE

☐ RETRO

REQUEST DATE:

PCP NAME:

PHONE #:

FAX #:

PCP NPI NUMBER:

PATIENT NAME

MEMBER ID#

MAILING ADDRESS

PHONE #

HEALTH PLAN:

PRODUCT LINE:

☐ MALE

☐ FEMALE

DATE OF BIRTH

SUBSCRIBER NAME

SUBSCRIBER RELATIONSHIP TO PATIENT

REQUESTED SPECIALIST

PHONE #

PRELIMINARY DIAGNOSIS

ICD-10 CODE

REQUESTED SERVICE

CPT CODE

QUANTITY

LOCATION (eg MD office)

Outpatient

Inpatient

LOS

Anesthesiologist Name:

***All post-op services including office visits require the date of surgery to be indicated. All requests for obstetrical care should include the last LMP, EDC and scheduled facility for delivery. All pertinent information should be stated on all requests. Attach progress notes and additional reports if applicable.**

***CONSULTATIONS ONLY: PLEASE ANSWER THE FOLLOWING QUESTIONS:**

TO BE COMPLETED BY PCP

1. SPECIFIC ISSUES TO BE ADDRESSED BY CONSULTANT:

A) CHECK IF CO-MANAGEMENT REQUESTED ☐

B) TAKE OVER CARE OF PROBLEM ☐

2. PERTINENT HISTORY & PHYSICAL EXAM DETAILS:

3. RELEVANT TREATMENT HISTORY INCLUDING MEDICATIONS/LAB/X-RAY/OTHER TEST RESULTS:

Requesting Provider Signature & Date:

Supervising Physician/Medical Navigator Signature:

Form completed by:

Title:

Tel #

Please Note: This form should be filled out in its entirety. If the form is not completely filled out and legible, it may be returned to your office for proper submittal, which will delay the authorization process.