AUTHORIZATION REQUEST FORM

INTERNAL WORKSHEET NOT FOR PAYMENT

c/o MedPOINT Management
P.O. Box 571450, Tarzana CA 91357
Phone: 800-509-8359 ♦ Fax: 818-791-4020

AHP OF SOUTHERN CALIFORNIA

FORM MUST BE FULLY COMPLETED BY PRIMARY CARE PHYSICIAN'S (PCP) OFFICE. AUTHORIZATION IS VALID FOR 90 DAYS FROM DATE INDICATED BELOW	☐ STAT ☐ ROUTINE	☐ URGENT ☐ RETRO	☐ PATIENT REQUEST

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.