



WESTSIDE DIVISION

AUTHORIZATION REQUEST FORM

INTERNAL WORKSHEET **NOT FOR PAYMENT**

c/o MedPOINT Management
P.O. Box 570997, Tarzana CA 91357
Phone: 818-702-0100 ♦ Fax: 818-466-6536

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) |
|-------------------|----------|----------|-------------------------|
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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.