

- Retro:** All necessary information received at time of request
- Urgent:** Requires immediate action, although not life threatening
- Routine:** Diagnostic studies, elective surgeries, consults, and follow-up

Auth./tracking number: _____

Authorization valid 6 months from date of approval.

| | | | | | |
|--|--|---------------------------|--|-----------|-----|
| Patient name | | Patient/member ID No./SSN | | Insurance | |
| Address | | City | | ZIP | Sex |
| DOB | | Phone | | Language | |
| Mother's full name (if member is under 21) | | | | | |

| | | | |
|-----------------------------|-----|----------------------------|-----|
| PCP name | | Referral to | |
| Name of requesting provider | | Address | |
| Contact person at office | | Phone | |
| Phone | Fax | Phone | Fax |
| MD signature | | Date signed/date requested | |

ATTACH ANY CONSULTATION REPORTS, X-RAY REPORTS, OR ANY PERTINENT DOCUMENTATION TO SUPPORT MEDICAL NECESSITY.

| | | | | | |
|---|--|-----------------------------|--|------------------------|--|
| Number of visits requested | | Appointment dates, if known | | Place of Service (POS) | |
| Name of surgical facility | | Date of surgery | | | |
| Diagnosis | | ICD-10 code | | | |
| Procedure requested | | CPT code | | | |
| Age, sex, history, physical exam, diagnosis, pertinent work up to date (i.e., diagnostic studies) | | | | | |
| Treatment plan | | | | | |

COMPLETED BY IPA

| | | | | | |
|---|--|----------------------|--|---|--|
| Date and time approved | | Date and time PENDED | | Initial notification to PCP date/time | |
| Date and time reviewed by UMC | | Date and time DENIED | | Written notice to PCP date/time | |
| Medical reviewer | | | | Written notice to member date/time | |
| Date returned | | | | Fax completed referral forms to: (916) 424-6200 | |
| UPON ACCEPTANCE OF REFERRAL AND TREATMENT OF THE PATIENT, PHYSICIAN/PROVIDER AGREES TO ACCEPT IPA CONTRACTED RATES. This referral/authorization verifies medical necessity only. Payments for services are dependent upon the patient's eligibility at the time services are rendered. | | | | Authorizations Department telephone: (916) 228-4300, option 1 | |
| PHYSICIAN REVIEWER AVAILABLE TO DISCUSS DECISION AND CRITERIA USED FOR DECISION AT (916) 228-4300 | | | | | |