Rady Children's Health Network

Authorization Request Form

3020 Children's Way M/C 5012
San Diego, CA 92123

Fax to: (858)309-7977

Phone: (877)276-4543
www.CPMGSanDiego.com

INSTRUCTIONS

- Authorization MUST be obtained prior to rendering services for any service requiring authorization (See Quick Reference Guide).
- Please attach all relevant medical documentation (i.e. visit notes, labs, etc.).
- Authorization of services is not a guarantee of payment and is dependent upon the patient's eligibility/benefits at the time services are rendered.

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH	HEALTH PLAN ID

PATIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	PATIENT'S PHONE NUMBER

HEALTH PLAN: ☐ Aetna ☐ Anthem Blue Cross ☐ Blue Shield ☐ Cigna ☐ Community Health Group
☐ Health Net ☐ Molina ☐ Scripps Health Plan ☐ Sharp Health Plan ☐ United Healthcare

PRODUCT:
☐ HMO ☐ Medi-Cal ☐ Other: _____

PCP NAME	PCP PHONE NO.	PCP FAX NO.

REQUESTING M.D. (IF OTHER THAN PCP)	DATE PREPARED	PREPARED BY	CONTACT PHONE NO.	CONTACT FAX NO.

CCS ELIGIBLE CONDITION? (CHECK ONE)	Has a CCS Referral Been Made? (Check One):	Date CCS Referral Made:
☐ Yes ☐ No	☐ Yes ☐ No	

SERVICE INFORMATION

☐ **Routine**
☐ **Retro** – Date(s) of Service: _____
☐ **Urgent** – **ONLY** for use when the standard 5-day process would seriously jeopardize the life or health of the member.

CHECK ALL THAT APPLY:

☐ Inpatient Length of Stay _____ ☐ Outpatient ☐ Specialty: _____
☐ Out of Network, Physician Request ☐ Out of Network, Patient Request ☐ Injectable ☐ Infusion
☐ DME Rental – Dates Requested: From _____ To _____ ☐ DME Purchase (Attach Quote)

PROVIDER NAME	PHONE NO.	FAX NO.

PROVIDER ADDRESS (IF OUT OF NETWORK, INCLUDE TAX ID NO. AND NPI)

PROCEDURE(S)	QTY.	CPT CODE	DIAGNOSIS	ICD-10 CODE

NOTES: