

Authorization Request Form

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

Fax to: (858)309-7977

Phone: (877)276-4543
network.radychildrens.org

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: <input type="checkbox"/> Aetna <input type="checkbox"/> Anthem Blue Cross <input type="checkbox"/> Blue Shield <input type="checkbox"/> Cigna <input type="checkbox"/> Community Health Group <input type="checkbox"/> Health Net <input type="checkbox"/> Molina <input type="checkbox"/> Scripps Health Plan <input type="checkbox"/> Sharp Health Plan <input type="checkbox"/> United Healthcare				
PRODUCT: <input type="checkbox"/> HMO <input type="checkbox"/> Medi-Cal <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No	Has a CCS Referral Been Made? (Check One): <input type="checkbox"/> Yes <input type="checkbox"/> No		Date CCS Referral Made:	

SERVICE INFORMATION

<input type="checkbox"/> Routine		
<input type="checkbox"/> Retro – Date(s) of Service: _____		
<input type="checkbox"/> Urgent – ONLY for use when the standard 5-day process would seriously jeopardize the life or health of the member.		
CHECK ALL THAT APPLY:		
<input type="checkbox"/> Inpatient Length of Stay _____ <input type="checkbox"/> Outpatient <input type="checkbox"/> Specialty: _____		
<input type="checkbox"/> Out of Network, Physician Request <input type="checkbox"/> Out of Network, Patient Request <input type="checkbox"/> Injectable <input type="checkbox"/> Infusion		
<input type="checkbox"/> DME Rental – Dates Requested: From _____ To _____ <input type="checkbox"/> 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:
