CENTRAL CALIFORNIA ALLIANCE FOR HEALTH®

SERVICE CATEGORY

5

CONFIDENTIAL PATIENT INFORMATION

1 FOR F.I. USE ONLY

CCN

F.I. USE ONLY

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TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

REQUEST IS RETROACTIVE ? YES NO

PROVIDER PHONE NO. ( )

PROVIDER NAME AND ADDRESS

PLEASE TYPE YOUR NAME AND ADDRESS HERE

FAX # ( )

PROVIDER NPI#

PATIENTS AUTHORIZED REPRESENTATIVE (IF ANY)
ENTER NAME AND ADDRESS:

FOR STATE USE

PROVIDER: YOUR REQUEST IS:

APPROVED AS REQUETED | DENIED | DEFERRED

APPROVED AS MODIFIED

BY: PHC CONSULTANT'S NAME

DATE M M D D Y Y

REVIEW COMMENT INDICATOR

COMMENTS / EXPLANATION

NAME AND ADDRESS OF PATIENT

PATIENT NAME (LAST, FIRST, M.I.)

PATIENT IDENTIFICATION NO.

STREET ADDRESS

SEX

AGE

DATE OF BIRTH M M D D Y Y

CITY, STATE, ZIP CODE

HOME | BOARD & CARE | SNF/ICF | ACUTE HOSPITAL

PHONE NUMBER
AREA
( )

DIAGNOSIS DESCRIPTION:

CURRENT ICD-10CM CODE

MEDICAL JUSTIFICATION:

LINE NO.	AUTHORIZED YES	AUTHORIZED NO	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC / UPC OR PROCEDURE CODE	QUANTITY	CHARGES
1								
2								
3								
4								
5								
6								

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN OR PROVIDER | TITLE | DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

FROM DATE M M D D Y Y

TO DATE M M D D Y Y

TAR CONTROL NUMBER

OFFICE | SEQUENCE NUMBER | PI

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBLITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.

RESET SAVE PRINT