



SERVICE
CATEGORY

5

CONFIDENTIAL PATIENT INFORMATION

1 FOR F.I. USE ONLY

CCN

F.I. USE ONLY

40 ☐ 41 ☐
42 ☐ 43 ☐

TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

PLEASE
TYPE YOUR
NAME AND
ADDRESS
HERE

PROVIDER NAME AND ADDRESS

REQUEST IS
RETROACTIVE ?

YES ☐ NO ☐

PROVIDER PHONE NO.

()

FAX #

()

PROVIDER NPI#

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

•
•
•
•

FOR STATE USE

PROVIDER: YOUR REQUEST IS:

☐ APPROVED AS REQUESTED ☐ 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

PHONE NUMBER
AREA

()

☐ HOME

☐ BOARD &
CARE

☐ SNF/ICF

☐ ACUTE
HOSPITAL

DIAGNOSIS DESCRIPTION:

CURRENT ICD-10CM CODE

MEDICAL JUSTIFICATION:

LINE NO.	AUTHORIZED		APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC / UPC OR PROCEDURE CODE	QUANTITY	CHARGES
	YES	NO						
1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			
2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			
3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			
4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			
5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			
6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			

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.

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

SIGNATURE OF PHYSICIAN OR PROVIDER

TITLE

DATE

OFFICE

SEQUENCE NUMBER

PI

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