



SNF ONLY SERVICE AUTHORIZATION REQUEST

URGENT

ROUTINE

RETROACTIVE

I. PATIENT INFORMATION

PRIMARY LANGUAGE SPOKEN: _____

Require Interpreter: Yes No American Sign Language

Member Name: _____ DOB: _____ Gender: F M

Member Address: _____ City: _____ Zip: _____ Phone: _____

Member ID#: _____ Medicare Medi-Cal Cal MediConnect

II. REFER TO INFORMATION

Date of Request: _____ Provider Name: _____ Specialty: _____

Provider Address: _____ Phone: _____ Fax: _____

Facility Name: _____ Phone: _____ Fax: _____

III. AUTISM

Autism Diagnostic Evaluation

IV. SERVICE(S) REQUESTED (Use ICD-10 Codes for Date of Service Request on or after 10/01/2015)

Initial Consult FU Visit(s) _____ Health Education (Specify): _____

Inpatient Admission Outpatient procedure(s) Other: _____

Diagnosis: _____ ICD-10 Code(s): _____

Service(s)/Procedure(s): _____ CPT 4 Code(s): _____

Reason for Request: _____

Relevant labs/X-Rays, etc.: _____

Prior Treatment & Results: _____

Requesting Physicians Name: _____ Phone #: _____

Physician's Signature: _____ Fax #: _____

Accident: YES NO Where Occurred: Home Work Auto Other

STATUS: APPROVED MODIFIED DEFERRED DENIAL

Auth #: _____ Date Approved: _____ Date Auth. Expire: _____

Comments: _____

Reviewer's Name: _____ Signature: _____ Date: _____

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN USE ONLY: Member Eligibility as of: _____

IPA RESPONSIBILITY Date faxed to IPA: _____ PCP Provider ID#: _____

THIS REFERRAL DOES NOT GUARANTEE ELIGIBILITY. CHECK ELIGIBILITY PRIOR TO RENDERING SERVICE. Payment will NOT be made for unauthorized services. All lab and x-rays must be ordered/performed by contracting providers Contact Blue Shield of California Promise Health Plan U.M. Department at above number, if unsure. Specialist reports must be sent to PCP promptly.