SANTÉ COMMUNITY PHYSICIANS

MEDI-CAL MANAGED CARE
REQUEST FOR PRIOR AUTHORIZATION
Fax (833)853-8550 / PHONE (559)228-4488

"Form to be completed in Full"

" Incomplete forms will be returned for information "

URGENT for acute conditions requiring care within 72 hours or less.

Level of Function/Current Functional Status/Current Clinical Status/Justification for Skilled Care:

Current Functional Status (Detail) :

Home Bound ? Yes No

PATIENT INFORMATION

Patient Name: Last	First	MI	Date of Birth (Mo/Day/Yr)
I.D.#	Health Plan:	Prior Auth #s:	Gender: M F

REQUESTING PHYSICIAN

Requesting Physician	Tax ID#

HOME HEALTH AGENCY / INFORMATION

Physician/Provider/Facility Requested	Address	
Contact Person	Telephone	Fax

CLINICAL INFORMATION

ICD-10 Codes (required) 1 2 3	Diagnosis Description:	Teachable Caregiver YES NO
	Recent Hospital Stay / Discharge:	Other:
CPT/HCPC Codes (required) 1 2 3 4	Discharge From: (Describe)	Other Clinic Referral

Discipline	Eval	Frequency	Pre-Auth	# of Visits	Start Date	End Date	Visits Auth.Office USE ONLY*	Comments:	Wound Status
SN									Location:
PT									Stage:
OT									Tunnel yes or no
ST									Measurements
HHA									Drainage
MSW									Current Treatment
						*Auth #			If >1 wd include wd sheet

Within 5 days before the actual date of service, provider MUST confirm that the member's health plan coverage is still in effect. With the exception of urgent requests, it is recommended that you do not schedule appointments prior to authorization approval. **Authorization does not guarantee payment**. Emergency services do not require prior authorization and are reviewed retrospectively for necessity.This message is intended only for the use of the individual/entity to which it is addressed and may contain confidential information. If the reader of this message is not the intended recipient, you are hereby notified that any distribution is strictly prohibited.