CONFIDENTIAL PATIENT INFORMATION

FOR F.I. USE ONLY

C.C.N.

F.I. USE ONLY

40 ☐ 41 ☐ 42 ☐ 43 ☐

SERVICE CATEGORY ☐

TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

(PLEASE TYPE) FOR PROVIDER USE (PLEASE TYPE)

VERBAL CONTROL NO.

TYPE OF SERVICE REQUESTED 2 ☐ DRUG ☐ OTHER

REQUEST IS RETROACTIVE? ☐ YES ☐ NO

IS FAMILY INCOME PLANNING? ☐ YES ☐ NO

PROVIDER PHONE NO. ( )

PLEASE TYPE YOUR NAME AND ADDRESS HERE

PROVIDER NAME AND ADDRESS

•
•
•
•
•

3. PROVIDER NUMBER

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:

•
•
•
•

NAME AND ADDRESS OF PATIENT

PATIENT NAME (LAST, FIRST, M.I.) 4

MEDI-CAL IDENTIFICATION NO. 5 ☐ CODE 6 ☐

STREET ADDRESS

CITY, STATE, ZIP CODE

PHONE NUMBER AREA ( )

SEX 7 ☐ AGE ☐ DATE OF BIRTH 8

PATIENT STATUS: ☐ HOME ☐ BOARD & CARE ☐ SNF / ICF ☐ ACUTE HOSPITAL

DIAGNOSIS DESCRIPTION:

ICD-9-CM DIAGNOSIS CODE

MEDICAL JUSTIFICATION.

FOR STATE USE

33 PROVIDER; YOUR REQUEST IS:

☐ APPROVED AS REQUESTED ☐ DENIED ☐ DEFERRED

☐ APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED) ☐ JACKSON VS RANK PARAGRAPH CODE

BY _____

MEDI-CAL CONSULTANT I.D. # 34 ☐ DATE 35 ☐ REVIEW COMMENTS INDICATOR 44 ☐

COMMENTS/EXPLANATION

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51303 (b)

36 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

LINE	AUTHORIZED ITEM							
1	9 ☐	10 ☐		☐	11	12 ☐	$
2	13 ☐	14 ☐		☐	15	16 ☐	$
3	17 ☐	18 ☐		☐	19	20 ☐	$
4	21 ☐	22 ☐		☐	23	24 ☐	$
5	25 ☐	26 ☐		☐	27	28 ☐	$
6	29 ☐	30 ☐		☐	31	32 ☐	$

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

37 FROM DATE 38 TO DATE

TAR CONTROL NUMBER

39 OFFICE SEQUENCE NUMBER 40525537 PI

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

60-2 03/07

SEND TO FIELD SERVICES (F.I. COPY)

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM