



BY INNOVATIVE INTEGRATED HEALTH

FRESNO PACE | BAKERSFIELD PACE | ORANGE COUNTY PACE

REQUEST FOR PRIOR AUTHORIZATION

PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____
(LAST, FIRST, MI) (MO/DAY/YR)

PACE I.D.#: _____ GENDER: M F

SERVICES REQUIRING PRIOR AUTHORIZATION (PLEASE CHECK REQUESTED SERVICE)

- | | |
|---|---|
| <input type="checkbox"/> Cardiac Testing (Echo, Stress Test-Treadmill, Holter, Carotid US, Nuclear Study, Stress ABI, etc.) | <input type="checkbox"/> Infusions - Ambulatory |
| <input type="checkbox"/> Colonoscopy; EGD | <input type="checkbox"/> Injections: Self-injectables; In-office injectable |
| <input type="checkbox"/> Dental Procedure (Implants, Bridges, Crowns, etc.) | <input type="checkbox"/> MRI, MRA, CT & Pet Scans |
| <input type="checkbox"/> Dermatology Procedures | <input type="checkbox"/> Obesity Surgery |
| <input type="checkbox"/> DME Purchase over \$100 | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> DEXA Scan | <input type="checkbox"/> Pulmonary Function Tests (PFT) |
| <input type="checkbox"/> Genetic Testing | <input type="checkbox"/> Thyroid US and Biopsy |
| | <input type="checkbox"/> Sleep Studies |

TYPE OF REQUEST

- URGENT for acute conditions requiring care within 72 hours or less.
- NON-URGENT for routine, elective service

TYPE OF SERVICE

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Inpatient | <input type="checkbox"/> Outpatient |
| <input type="checkbox"/> 2 nd Opinion Consult | <input type="checkbox"/> Consult |
| <input type="checkbox"/> Consult and Treat | <input type="checkbox"/> Other |

FROM - REQUESTING PHYSICIAN

Provider:	Tax I.D.#:
Contact Person:	Phone Number:
Physician's Signature:	Date:

REFERRED TO:

SPECIALIST NAME (PRINT)	PHONE#	FAX
ADDRESS		

CLINICAL INFORMATION

ICD-10 Codes (required)	Diagnosis Description:	
CPT/HCPC Codes (required)	CPT Description:	Quantity Req.:
Comments:		

ATTACH APPROPRIATE MEDICAL RECORDS TO EXPEDITE REFERRAL:

- | | | |
|---|---|---|
| <input type="checkbox"/> PROGRESS NOTES | <input type="checkbox"/> CONSULTANT'S NOTES | <input type="checkbox"/> NOTES WITH SPECIFIC FINDINGS |
| <input type="checkbox"/> EKG | <input type="checkbox"/> LAB REPORT | <input type="checkbox"/> X-RAY REPORT |
| <input type="checkbox"/> IMAGING STUDY REPORT | <input type="checkbox"/> MEDICATIONS LIST | <input type="checkbox"/> CARDIAC RELATED STUDIES |
| <input type="checkbox"/> IMMUNIZATION RECORD | <input type="checkbox"/> OTHER _____ | |

FAX COPY TO (855) 779-9584

Authorization is not guarantee of payment. Payment is dependent upon eligibility and covered benefits at the time services are rendered.