



1800 Height Street • Bakersfield, CA 93305
 PHONE (661) 872-3860 • FAX (855) 824-5660

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"/> Colonoscopy; EGD <input type="checkbox"/> Dental Procedure (Implants, Bridges, Crowns, etc.) <input type="checkbox"/> Dermatology Procedures <input type="checkbox"/> DME Purchase over \$100 <input type="checkbox"/> DEXA Scan <input type="checkbox"/> Genetic Testing | <input type="checkbox"/> Infusions - Ambulatory <input type="checkbox"/> Injections: Self-injectables; In-office injectable <input type="checkbox"/> MRI, MRA, CT & Pet Scans <input type="checkbox"/> Obesity Surgery <input type="checkbox"/> Out-of-Plan Provider <input type="checkbox"/> Pulmonary Function Tests (PFT) <input type="checkbox"/> Thyroid US and Biopsy <input type="checkbox"/> Sleep Studies |

| TYPE OF REQUEST |
|--|
| <input type="checkbox"/> URGENT for acute conditions requiring care within <u>72 hours or less.</u> <input type="checkbox"/> 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) 824-5660

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