



CenCal Health
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Long Term Care Authorization Request

CONFIDENTIAL PATIENT INFORMATION

FOR PROVIDER USE (PART 1)

(PLEASE TYPE)

REQUEST IS RETROACTIVE?
 YES NO

PROVIDER PHONE
 ()
 AREA

PLEASE TYPE YOUR NAME AND ADDRESS HERE

PROVIDER NAME AND ADDRESS

PROVIDER NUMBER

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

PATIENT IDENTIFICATION NO.

ADMIT DATE

OTHER

DATE

SEX

DATE OF BIRTH

SOCIAL SECURITY CLAIM NO.

THIS SERVICE

COVERAGE

BENEFITS EXHAUSTED

PART 2 TO BE COMPLETED BY ATTENDING PHYSICIAN

PERIOD OF CARE REQUESTED

(FROM) DATE

(TO) DATE

PRIM. DX CODE

CURRENT DIAGNOSES

A. (PRIMARY)

(SECONDARY)

ADMITTED FROM

NOTES:

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.

CONTROL NUMBER

A 126758

SIGNATURE OF PHYSICIAN

DATE

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