

STATE  
USE  
ONLY

4

# CONFIDENTIAL PATIENT INFORMATION

FOR F.I. USE ONLY  
CCN

F.I. USE ONLY  
40 41  
42 43

SERVICE CATEGORY

TYPEWRITER ALIGNMENT  
Elite Pica

## TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES

TYPEWRITER ALIGNMENT  
Elite Pica

(PLEASE TYPE)

FOR PROVIDER USE

(PLEASE TYPE)

VERBAL CONTROL NO. TYPE OF SERVICE REQUESTED REQUEST IS RETROACTIVE? IS PATIENT MEDICARE ELIGIBLE? PROVIDER PHONE NO.

PROVIDER NAME AND ADDRESS  
3: PROVIDER NUMBER

NAME AND ADDRESS OF PATIENT  
PATIENT NAME (LAST, FIRST, MI)  
MEDICAL IDENTIFICATION NO.  
SEX AGE DATE OF BIRTH  
STREET ADDRESS  
CITY, STATE, ZIP CODE  
PHONE NUMBER (AREA)

DIAGNOSIS DESCRIPTION: ICD-9-CM DIAGNOSIS CODE  
MEDICAL JUSTIFICATION:

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

### FOR STATE USE

33 PROVIDER; YOUR REQUEST IS:  
1 APPROVED AS REQUESTED DENIED DEFERRED  
2 APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED) JACKSON VS RANK PARAGRAPH CODE  
BY I.D.# MEDICAL CONSULTANT DATE REVIEW COMMENTS INDICATOR  
34 35 44

COMMENTS/EXPLANATION  
RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51903 (c)  
1 2 3 4 5 6

| LINE NO. | AUTHORIZED               |                          | APPROVED UNITS | SPECIFIC SERVICES REQUESTED | UNITS OF SERVICE | NDC/IPC OR PROCEDURE CODE | QUANTITY | CHARGES |
|----------|--------------------------|--------------------------|----------------|-----------------------------|------------------|---------------------------|----------|---------|
|          | YES                      | NO                       |                |                             |                  |                           |          |         |
| 1        | <input type="checkbox"/> | <input type="checkbox"/> |                |                             |                  |                           |          | \$      |
| 2        | <input type="checkbox"/> | <input type="checkbox"/> |                |                             |                  |                           |          | \$      |
| 3        | <input type="checkbox"/> | <input type="checkbox"/> |                |                             |                  |                           |          | \$      |
| 4        | <input type="checkbox"/> | <input type="checkbox"/> |                |                             |                  |                           |          | \$      |
| 5        | <input type="checkbox"/> | <input type="checkbox"/> |                |                             |                  |                           |          | \$      |
| 6        | <input type="checkbox"/> | <input type="checkbox"/> |                |                             |                  |                           |          | \$      |

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 70008673 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. SEND TO FIELD SERVICES (F.I. COPY)