

# AUTHORIZATION REQUEST FORM

URGENT\*\*    ROUTINE    RETRO\*   Fax (805) 681-3071 or send via secure link: <https://gateway.cencalhealth.org/form/hs>

\*\*\* IN ORDER TO PROCESS YOUR REQUEST, FORM MUST BE COMPLETE AND LEGIBLE \*\*\*

\*\* URGENT is only when normal time frame for authorization will be detrimental to patient's life or health; jeopardize patient's ability to regain maximum function; or result in loss of life, limb, or other major bodily function. URGENT requests are addressed within 72 hours.

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_  
Last First

Member ID# (CIN): \_\_\_\_\_ D.O.B: \_\_\_\_\_ Age: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD-10: \_\_\_\_\_

## NEW REFERRAL AUTHORIZATION (RAF)

### Referring Provider:

\_\_\_\_\_

MD NPI#: \_\_\_\_\_ Group NPI#: \_\_\_\_\_

Address: \_\_\_\_\_

Office Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Is the Referring Provider the PCP?  YES  NO

### Provider Rendering Service (Physician, Facility, Vendor):

\_\_\_\_\_

MD NPI#: \_\_\_\_\_ Group NPI#: \_\_\_\_\_

Address: \_\_\_\_\_

Office Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Is the Rendering Provider CCS Panelled?  YES  NO

## FACILITY AUTHORIZATION REQUEST (18-1) & (20-1)

Inpatient Facility    Outpatient Facility    SNF

Effective Date: \_\_\_\_\_ Through Date: \_\_\_\_\_

Facility NPI: \_\_\_\_\_ Facility Address: \_\_\_\_\_

Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## LIST ALL PROCEDURES REQUESTED ALONG WITH THE APPROPRIATE CPT/HCPCS (50-1)

REQUESTED PROCEDURES:	CODE (CPT or HCPCS)	QTY (REQUIRED)	UNITS (REQUIRED)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

To prevent delays, please fax all medical documents to support your request with this form.

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