AUTHORIZATION REQUEST FORM

CenCal HEALTH®
Local. Quality. Healthcare.

○ URGENT** ○ ROUTINE ○ RETRO* **Fax (805) 964-0367 or send via secure link: https://gateway.cencalhealth.org/form/pharmacy**

*** 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 Paneled? ○ 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.