

## Authorization Request Form

PO Box 23076, San Diego, CA 92193  
 Phone: (877)276-4543

Fax to: (858)309-7977

[www.CPMGSanDiego.com](http://www.CPMGSanDiego.com)

### INSTRUCTIONS

- Authorization MUST be obtained prior to rendering services for any service requiring authorization (See Quick Reference Guide).
- Please attach all relevant medical documentation (i.e. visit notes, labs, etc.).
- Authorization of services is not a guarantee of payment and is dependent upon the patient's eligibility/benefits at the time services are rendered.

### PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)		DATE OF BIRTH	HEALTH PLAN ID	
PATIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)			PATIENT'S PHONE NUMBER	
HEALTH PLAN: <input type="checkbox"/> Aetna <input type="checkbox"/> Anthem Blue Cross <input type="checkbox"/> Blue Shield <input type="checkbox"/> Cigna <input type="checkbox"/> Community Health Group <input type="checkbox"/> Health Net <input type="checkbox"/> Molina <input type="checkbox"/> Scripps Health Plan <input type="checkbox"/> Sharp Health Plan <input type="checkbox"/> United Healthcare				
PRODUCT: <input type="checkbox"/> HMO <input type="checkbox"/> Medi-Cal <input type="checkbox"/> California Kids <input type="checkbox"/> Other: _____				
PCP NAME		PCP PHONE NO.	PCP FAX NO.	
REQUESTING M.D. (IF OTHER THAN PCP)	DATE PREPARED	PREPARED BY	CONTACT PHONE NO.	CONTACT FAX NO.
CCS ELIGIBLE CONDITION? (CHECK ONE)	Has a CCS Referral Been Made? (Check One):		Date CCS Referral Made:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			

### SERVICE INFORMATION

**Routine**  
 **Retro** – Date(s) of Service: \_\_\_\_\_  
 **Urgent** – **ONLY** for use when the standard 5 day process would seriously jeopardize the life or health of the member.

#### CHECK ALL THAT APPLY:

Inpatient Length of Stay \_\_\_\_\_     
 Outpatient     
 Specialty: \_\_\_\_\_  
 Out of Network, Physician Request     
 Out of Network, Patient Request     
 Injectable     
 Infusion  
 DME Rental – Dates Requested: From \_\_\_\_\_ To \_\_\_\_\_     
 DME Purchase (Attach Quote)

PROVIDER NAME	PHONE NO.	FAX NO.
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PROVIDER ADDRESS (IF OUT OF NETWORK, INCLUDE TAX ID NO.)

PROCEDURE(S)	QTY.	CPT CODE	DIAGNOSIS	ICD-10 CODE

NOTES:

### For CPMG Use Only

<input type="checkbox"/> Approved	INITIALS	DATE
<input type="checkbox"/> Cancelled – Duplicate	INITIALS	DATE
<input type="checkbox"/> Cancelled – No Prior Authorization Required	INITIALS	DATE
<input type="checkbox"/> Redirect to Behavioral Health	INITIALS	DATE
<input type="checkbox"/> Redirect to Health Plan	INITIALS	DATE
<input type="checkbox"/> Redirect to Vision	INITIALS	DATE