FAX To (805) 685-7781

CenCal Health Use Only

CenCal HEALTH
Local. Quality. Healthcare.

CenCal Health Medical Request Form (MRF)

(Please Print)

Exceeded 7 Rx Monthly Limit? ☐ Yes ☐ No

Today's Date

Member ID

Member Name	ID #	Birthdate
Member Address		Member Phone No.
PCP Name	Is patient Medi-Care eligible? ☐ Yes ☐ No	Patient Status ☐ Home ☐ Board & Care ☐ NF/ICF ☐ Acute Hospital

Prescriber

Prescriber Name	Specialty	Phone No.	FAX No.
DEA #	Medi-Cal No.	NPI #	
Mailing Address/E-mail Address		Pharmacy Name/Fax No.	

REQUESTED MEDICATION INFORMATION

Drug Name/Strength (mg)/Dosing schedule	Estimated length of drug therapy (1 month, etc./why?)
Diagnosis	ICD-10 Code(s)

Request is retroactive? ☐ Yes ☐ No

If yes, explain:

Please explain why you are requesting the use of this medication:

Previous Medications Tried:

Medication / Strength	Outcome of Medication Tried

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
X		

Reviewer

CenCal Health Staff Use Only

Provider, your request is: ☐ Approved as requested ☐ Approved as modified ☐ Denied ☐ Deferred

Reviewer's Signature X

I.D. #	Date	Comments/Explanation

Approved Units	NDC#/PMI#/GPI#	Quantity	Specific Services Requested

Authorization is valid for services provided from _____ (Date) to _____ (Date)

12/2014

4050 Calle Real
Santa Barbara, CA 93110
(800) 421-2560, Ext. 1080
Direct Dial (805) 562-1080
www.cencalhealth.org

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