

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 Panned? 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.
4050 Calle Real, Santa Barbara, CA 93110 • (805) 562-1082