UCSD PHSO Managed Care

UCSD Managed Care UM Department

AUTHORIZATION REQUEST FORM

Fax completed form to UCSD PHSO Managed Care
UM Department at:
619-471-9100 Routine/Urgent/Stat
Please fax notes for requests (ex. PT/OT/ST, Out of Network)

Pt. Name
DOB
Sex
Medical Record #

Primary Care Physician	Requesting Physician.	Date
Telephone	Telephone	
Fax	Fax	
IPA/Medical Group	Name of Insured	SS# of Insured
Health Plan/Patient ID#	Person Completing Form	Phone

INSTRUCTIONS: TO BE COMPLETED BY PCP OR SPECIALIST. NOTE: AUTHORIZATION VALID FOR 90 DAYS FROM DATE OF APPROVAL

■ PRIOR AUTHORIZATION **Out of Network providers must include NPI, Tax ID, address, phone, fax and contact name**	For Coordination of Benefits (COB) – Check One: Elective: DOS_____ Worker's Compensation	
Referral To: *(Must be UCSD Contracted Physician)*	Diagnosis: 1 -	ICD-10 Code: 1 -
Phone:	2 -	2 -
Fax:	3 -	3 -

SERVICE REQUESTED (CPT CODE REQUIRED)

☐ PT ☐ OT	☐ Speech - Outpatient ☐ Speech - Home	☐ Mental Health – Inpatient ☐ Mental Health - Outpatient
☐ Emergency Room ☐ Urgent Care Facility/Hospital: _____ DOS: _____		☐ DME Item Description: _____
Home Health: ☐ RN ☐ MSW ☐ LVN ☐ HH Aide Frequency: _____	☐ Vision Care/Phys ☐ Radiology Procedure: _____	☐ Transportation Reason: _____
Other:	Special Instructions (# of tx, surgery or procedure):	

PROCEDURE/SURGERY REQUESTED BY SPECIALIST OR PRIMARY CARE PHYSICIAN

☐ Outpatient ☐ Inpatient ☐ Office	Date:	
Facility Name	Requested LOS if Inpatient:	
Procedure	Expected DOS	CPT
Procedure	Expected DOS	CPT
Clinical Justification for Referral (include all pertinent documentation)		
Attached Reports: ☐ Lab ☐ X-Ray ☐ Medications ☐ Progress ☐ Notes		

FOR UCSDMC USE ONLY

ONLINE AUTHORIZATION TRACKING SYSTEM <OATS>		
PCP Concurrence:		
◯ Approved ◯ Denied ◯ Pended	Reviewing MD Signature:	Date