CenCal HEALTH™

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Medical Authorization Request

CONFIDENTIAL PATIENT INFORMATION

FOR PROVIDER USE (PLEASE TYPE)

REQUEST IS RETROACTIVE? ☐ ☐ OTHER COVERAGE ☐ ☐ PROVIDER PHONE ( )

For CenCal Health Use Only

PROVIDER NUMBER

PLEASE TYPE YOUR NAME AND ADDRESS HERE

NAME AND ADDRESS OF PATIENT

PATIENT NAME (LAST, FIRST, M.I.)

PATIENT IDENTIFICATION NO.

SEX AGE DATE OF BIRTH

STREET ADDRESS

CITY, STATE, ZIP CODE

PHONE NUMBER area ( )

PATIENT STATUS: ☐ HOME ☐ BOARD & CARE ☐ SNF / ICF ☐ ACUTE HOSPITAL

DIAGNOSIS DESCRIPTION:

ICD-9-CM DIAGNOSIS CODE

MEDICAL JUSTIFICATION:

LINE NO.	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	UPC OR PROCEDURE CODE	QTY.	CHARGES
1					
2					
3					
4					
5					
6					

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

CONTROL NUMBER

A1237924

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