Today's Date: _____

Check One:
☐ URGENT
☐ ROUTINE
☐ RETROACTIVE

Primary Care ASSOCIATES OF CALIFORNIA Medical Group
PCAC

(310) 535-9289 Routine
(562) 531-4254 Urgent

Approved Auth. #

REFERRAL/AUTHORIZATION REQUEST FORM

PATIENT FIRST AND LAST NAME:

SEX (circle one):

MALE FEMALE

PATIENT PHONE NUMBER:
HOME WORK

DATE OF BIRTH (MM/DD/YYYY):

PATIENT HOME ADDRESS (STREET, CITY, STATE AND ZIP CODE):

HEALTH PLAN: _____ **HEALTH PLAN I.D. #:**_____

PRIMARY CARE PHYSICIAN NAME **PHONE #:**

REQUESTING PHYSICIAN NAME **PHONE #:**

REQUESTED PHYSICIAN or FACILITY NAME: **PHONE #:** **FAX #:**

REASON FOR REFERRAL (circle one): CONSULT FOLLOW UP PROCEDURE SUPPLY/DME TESTING

PLACE OF SERVICE (circle one): DOCTOR'S OFFICE HOME HEALTH INPATIENT HOSPITAL
OUTPATIENT HOSPITAL SKILLED NURSING FACILITY SURGERY CENTER OTHER_____

PRIMARY DIAGNOSIS/ICD-9CODES	REQUESTED CPT/RBRVS/HCPC CODES

PLEASE ATTACH CHART NOTES

Including test results, x-ray, lab results, consultation reports & all relevant clinical information

NOTE: Referral must be to a contracted specialist. Initial consult is a 99203.

ACCIDENT: YES NO **PLACE OF OCCURANCE:** HOME WORK AUTO OTHER:_____

DATE OF LAST VISIT TO PCP: _____/_____/_____ **DATE OF LAST VISIT TO SPECIALIST:** _____/_____/_____

PCP SIGNATURE: _____ **SPECIALIST SIGNATURE:** _____

FOR IPA USE ONLY

☐ APPROVED AS IS ☐ MODIFIED ☐ DENIED ☐ PENDING ☐ NON-COVERED BENEFIT

INSTRUCTIONS/EXPLANATION:

AUTHORIZED BY: _____ **DATE:** _____ **INITIALS:** _____