West Regional Physicians Network

c/o ProSource MSO, LLC
PO BOX 10939
San Bernardino, CA 92423
Phone: (323) 347-6815 *Fax: (323) 489-3220

Referral Authorization Request

Date Submitted: _____ Service Date: _____ Health Plan: _____

☐ **Routine** ☐ **Urgent/Expedited** ☐ **Retro** **FAX: (323) 347-6815**

PATIENT INFO

Patient Name:		DOB:	
Address:	City:	State:	Zip:
Phone: ( )		Member ID:	
Primary Insured's Name:		SS#	
Relationship to Patient: ☐SELF ☐SPOUSE ☐ CHILD ☐ OTHER: _____			

PROVIDER

PCP: _____ ADDRESS: _____ _____ Phone: _____ Fax: _____	**REFERRING M.D. (if not PCP)** **Referring MD**: _____ ADDRESS: _____ City/State/Zip: _____ Phone: _____ Fax: _____	**REQUESTED** **SPECIALIST:** _____ ADDRESS: _____ City/State/Zip: _____ Phone: _____ Fax: _____

Services Requested:

☐ Follow-Up Visit ☐Initial Consult ☐ Radiology
☐ PT/OT ☐Home Health ☐ Surgery
☐ DME: Specify _____
☐ Total OB Care: EDC _____ LMP _____

Specialty Requested:

☐ Cardiology ☐ Dermatology ☐ Psychiatry
☐ ENT ☐ Ophthalmology ☐ Pulmonary
☐ Orthopedics ☐ Oncology ☐ Other: _____
☐ Podiatry ☐ **Urology**

Diagnosis/ ICD-10:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Requested Procedure Description:

1. _____
2. _____
3. _____

CPT CODE(S): (Must be Included)

1. _____
2. _____
3. _____

Medical Necessity Information: _____

_____ _____
Referring Physician Signature

** ATTACH DOCUMENTATION TO FACILITATE DETERMINATION OF REFERRAL **

UTILIZATION MANAGEMENT COMMITTEE DECISION

UM COMMITTEE DECISION: ☐ APPROVED ☐ DENIED ☐ DEFERRED ☐ MODIFIED

COMMENTS: _____

UM REPRESENTATIVE SIGNATURE: _____ DATE: _____

*** Fax completed form to West Regional Physician Network IPA / ProSource MSO (323) 489-3220. Authorizations expire 90 days from approval date. Authorization does not guarantee payment. Payment pending verifications of eligibility. Please verify eligibility on date of service.**