



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: _____				
<input type="checkbox"/> Routine <input type="checkbox"/> Urgent/Expedited <input type="checkbox"/> 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: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> 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: <input type="checkbox"/> Follow-Up Visit <input type="checkbox"/> Initial Consult <input type="checkbox"/> Radiology <input type="checkbox"/> PT/OT <input type="checkbox"/> Home Health <input type="checkbox"/> Surgery <input type="checkbox"/> DME: Specify _____ <input type="checkbox"/> Total OB Care: EDC _____ LMP _____		Specialty Requested: <input type="checkbox"/> Cardiology <input type="checkbox"/> Dermatology <input type="checkbox"/> Psychiatry <input type="checkbox"/> ENT <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Pulmonary <input type="checkbox"/> Orthopedics <input type="checkbox"/> Oncology <input type="checkbox"/> Other: _____ <input type="checkbox"/> Podiatry <input type="checkbox"/> 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: <input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED <input type="checkbox"/> DEFERRED <input type="checkbox"/> 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.

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