MEMORIALCARE® MEDICAL GROUP

Date of Request: ___________________

Referral Authorization Request Form

****Requests lacking pertinent clinical documentation may experience a delay in processing****

Please follow authorization request parameters below based on clinical need, not clerical:

REQUEST IS:
- ☐ **ROUTINE - (Standard request processed within 5 business days)**
- ☐ **URGENT - (Medically necessary for authorization to be processed within 48 hours)**
- ☐ **EMERGENT - (Medically necessary for authorization to be processed within 24 hours)**

Please fax your request to the PCP office at the appropriate fax number below:

Aliso Viejo	Fax (714) 665-4626	**Anaheim**	Fax (714) 665-4625	**Costa Mesa**	Fax (714) 665-4624
Dana Point - All	Fax (714) 665-4697	**Fountain Valley - Brookhurst**	Fax (714) 665-4682	**Fountain Valley - Warner**	Fax (714) 665-4623
Huntington Beach - All	Fax (714) 665-4683	**Irvine**	Fax (714) 665-4622	**Long Beach – Bellflower (Los Altos)**	Fax (714) 665-4627
Long Beach – Spring	Fax (714) 665-4698	**MV – Madero**	Fax (714) 665-4621	**Rancho Santa Marg**	Fax (714) 665-4620
Santa Ana	Fax (714) 665-4692	**San Clemente - All**	Fax (714) 665-4697	**San Juan Cap**	Fax (714) 665-4619
Westminster	Fax (714) 665-4683	**DME**	Fax (714) 665-4634		

PLEASE PRINT LEGIBLY

Requesting Provider/Group Name:	**Requesting Provider Specialty:**	
Address:	**Office Contact Name:**	
	Phone:	**Fax:**

Patient Name: ____ **Date of Birth:** ______________________
First Middle Initial Last

PCP: __________________________ **Last Seen by You On:** _________________ **Date of Next Visit:** _________________

SERVICES REQUESTED:

CPT Code:	Brief Description of CPT Code/Service Requested:	ICD-10 Code:	ICD-10 Code Description:	Surgery Center/ Hospital Name:	Inpt or Outpt

ADDITIONAL INFORMATION NEEDED FOR OBSTETRICAL CARE REQUESTS:

LMP DATE:	# OF ULTRASOUNDS AND/OR NST'S ALREADY PERFORMED BY YOUR OFFICE:

Additional Notes: ____