Referral Authorization Request Form

All fields are mandatory. Chart notes are required and must be faxed with this request. Incomplete requests will be returned.

Fax to: (888) 564-8443

Patient Name:	DOB:
Requesting Provider/Facility:	
Requesting Provider/Facility Specialty:	
Requesting Provider/Facility Contact Name:	Email:
Requesting Provider/Facility Phone:	Fax:

Today's Date: _____

Request type based on <u>clinical need, not clerical</u>:

☐ Routine (standard 7-10 business days)

☐ Urgent (72 hours)

☐ Retro - Date of Service: _____

Requested Services:

☐ Office   ☐ ASC   ☐ Post-Acute   ☐ DME

☐ Outpatient Hospital*   ☐ Other

☐ Inpatient Acute - Admit Date: _____

Urgent/Expedited Requests are not to be used for scheduling convenience. The urgency of services is to be determined by the ordering provider based on the medical need of the enrollee.

*Plain film x-rays do NOT require pre-authorization when rendered at Loma Linda University Medical Center - Murrieta or RadNet facilities.

☐ **Please expedite!** This provider believes that waiting for a decision under the standard timeframe could place the enrollee's life, health or ability to regain maximum function in serious jeopardy.

CPT/HCPCS	Qty/Units	CPT Description	ICD-10	ICD-10 Description	Serving Facility

Clinical Documentation: Comment:

☐ Chart notes attached (required)

☐ Imaging Order attached (required)

☐ DME Order attached (required)

☐ Prescription attached (required)

Members must be eligible at time of service. Out-of-network requests may experience a delay.
To modify an existing request or for general inquiries, please contact the referral team at **(951) 894-4665, Option 5**.