TREATMENT AUTHORIZATION REQUEST - ATTACHMENT FORM

STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES

INTERNAL CONTROL NUMBER - FI USE ONLY

3

CONFIDENTIAL PATIENT INFORMATION PLEASE TYPE INFORMATION

PART I: PROVIDER INFORMATION

1 SUBMITTING PROVIDER # | 2 PATIENT RECORD # | 3 PROVIDER PHONE # | 4 PROVIDER FAX #

5 PROVIDER NAME | 10 MEDICARE CERTIFIED

6 PROVIDER STREET/MAILING ADDRESS | 11 PROVIDER CONTACT NAME

7 CITY | 8 STATE (CA) | 9 ZIP CODE | 12 PROVIDER CONTACT PHONE #

13 ORIGINAL TAR NUMBER | 14 UPDATE RSN | 15 SPCL HNDLG | 16 RETRO RSN | 17 RETRO DATE

PART II: PATIENT INFORMATION

31 MEDI-CAL IDENTIFICATION NUMBER | 32 PATIENT NAME, LAST | 33 FIRST | 34 SEX | 35 RES STAT | 36 WRC

TO THE BEST OF MY KNOWLEDGE, THE ABOVE IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN OR PROVIDER **DATE**

X

Note: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.

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