

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 #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5 PROVIDER NAME	10 MEDICARE CERTIFIED		
<input type="text"/>	<input type="checkbox"/>		
6 PROVIDER STREET/MAILING ADDRESS	11 PROVIDER CONTACT NAME		
<input type="text"/>	<input type="text"/>		
7 CITY	8 STATE	9 ZIP CODE	12 PROVIDER CONTACT PHONE #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
13 ORIGINAL TAR NUMBER	14 UPDATE RSN	15 SPCL HNDLG	16 RETRO RSN
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
			17 RETRO DATE
			<input type="text"/>

PART II: PATIENT INFORMATION

31 MEDI-CAL IDENTIFICATION NUMBER	32 PATIENT NAME, LAST	33 FIRST	34 SEX	35 RES STAT	36 WRC
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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	
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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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