시애틀 메디칼 그룹
SEATTLE MEDICAL GROUP

**Phone: 800-611-9862**
**Fax: 562-766-2001**

# REFERRAL AUTHORIZATION WORKSHEET

☐ **STANDARD** ☐ **RETRO** Service Date ___/___/___ ☐ **EXPEDITED/URGENT**

**Date Submitted**: ___/____/____ **Submitted By:** _____ (**Check Box & Sign Below Only if request is Urgent)**

## PATIENT INFORMATION

**Name:** **DOB:**

**Member ID:** **Health Plan:**

**Address**

**City** **State** **Zip**

## FEDERAL REGULATION 42 CFR 422.570 STATES:

Expedited requests are time sensitive situations where the standard time for issuing determinations could seriously jeopardize the life or health of the member or the member's ability to regain maximum function. Only a member, an authorized representative, or the member's physician may make such a request.

☐ **Physician** ☐ **Member** ☐ **Authorized Rep.**

**SIGNATURE:** _____

**Patient Phone#:** _____

## Authorizing Provider/Referring Physician/Requested by Provider

**Name** **Specialty**

**NPI** **TIN**

**Phone** **Fax**

**Address**

**City** **State** **Zip**

## Requested Provider/Performing Physician/Referring to Provider

**Name** **Specialty**

**NPI** **TIN**

**Phone** **Fax**

**Address**

**City** **State** **Zip**

## Medical Information

**CPT Codes (PLEASE SPECIFY QTY/UNITS)**

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| CPT CODE | | | | | |
| MODIFIER | | | | | |
| QUANTITY | | | | | |

☐ **See attached notes (Please list all CPT Codes & Quantity)**

**Facility Information** (If applicable)

Facility: _____

NPI: _____ TIN: _____

_____
Street Address

_____
City State Zip

**Place of Service:** (Check One)

☐ Office ☐ Outpatient Hospital

☐ Home ☐ Inpatient Hospital

☐ Ambulatory Surgery Center ☐ Other: _____

**ICD-10 Codes:**

Primary ICD-10: _____

ICD10: _____ ICD10: _____

ICD10: _____ ICD10: _____

ICD10: _____ ICD10: _____

## Clinical History & Findings:

Reason for referral: include symptoms, duration, findings on physical exam, lab or x-ray results, list of medications given.

☐ **See attached notes**

**Provider Signature**: _____

Fax completed form to the member's PCP. Responses will be computer generated and will include Tracking #. Authorizations expire 60 days from approval date. All claims must include Tracking #. Authorization does not guarantee payment. Payment pending verification of eligibility.