Authorization Referral Form

765 The City Drive South, Suite 200 Orange, CA 92868
Phone: (888) 505-4814 *option 1* Fax: (714) 908-8055

☐ Standard (Part C decision time 14 calendar days, Part B 72 hours)

☐ Expediated (Part C decision time 72 hours, Part B 24 hours)

☐ Retro

Member Demographics:

Date:	**Member Name:**	**DOB:**	**Male/Female (circle one)**
Member Address:			
Phone Number:	**Member ID:**		**PCP Name:**
Referring Physician:		**ICD 10 Codes:**	
Phone Number:	**Fax Number:**		**Request Date:**

Office Instructions:

Fax this form to Astiva MSO UM Department at (714) 908-8055 if this is a Specialist consult request also fax the information to the 'referred to Specialist'. Include all related Medical Records including progress notes, lab and radiology results.

Reason for Referral:

Refer to Provider:	**Specialty Service:**	**Contracted: Yes_____No_____**	
Address:		**NPI:**	
CPT Code:	**Service Requested:**	**Provider Phone:**	**Fax:**
Attached Information: Labs: _____Radiology: _____Progress Notes: _____ Other: _____			**POS:**
Clinical Information for referral:			
Requesting Provider Signature:		**Date:**	

If the physician would like to discuss this case with the Medical Director or would like a copy of the criteria used to make this decision, please call the number listed on the fax cover sheet of your decision letter. AUTHORIZATION IS CONTINGENT UPON MEMBER'S ELIGIBILITY ON DATE OF SERVICE Do not schedule non-emergent services until authorization is obtained.