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Southland Advantage Medical Group

REFERRAL AUTHORIZATION WORKSHEET
c/o HEALTHSMART MSO, INC., P.O. Box 6300, Cypress, CA 90630-0063
Phone: (714) 947-8600 UM Fax: (714) 947-8744

WARNING: This transmission contains protected health information that you are required by law to maintain in a secure and confidential manner. Re-disclosure is prohibited. Failure to maintain confidentiality or re-disclosure without authorization could result in penalties as described in State and Federal law. This message is intended as requested for authorization of services. The following is confidential and considered privileged by law. If the reader of this transmission is not the intended recipient or a designated party of behalf of, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you are not the intended recipient, please notify the UM Department at (714) 947-8600 and shred this information.

MEMBER INFORMATION ***(Please Note: Authorization Requests cannot be accepted without valid ID number and Date of Birth)***

Medicare MBI HIC#: | | | | | | | | | | | |

Health Plan ID#: | | | | | | | | | | | | | | | | | | | |

Medi-Cal CIN#: | | | | | | | | | |

Date of Birth: | | | / | | / | | | | |

Member Name: _____ Health Plan: _____
(Last, First)

MEDICAL INFORMATION/SERVICES REQUESTED ***(URGENT - Defined as "A situation where the time frame of the standard decision making process could seriously jeopardize the life or health of the enrollee, or could jeopardize the enrollee's ability to regain maximum function.")***

RETRO ☐ Date _____ ROUTINE ☐ URGENT ☐

Place of Service _____ Facility (if Any) _____

Requested Service: **(Please Note - Authorization Requests cannot be accepted without valid CPT and ICD-10 codes)**

	CPT Code	QTY		CPT Code	QTY		ICD-10 Code
1.			6.			1.	.
2.			7.			2.	.
3.			8.			3.	.
4.			9.			4.	.
5.			10.			5.	.

PHYSICIAN INFORMATION

Requesting Physician _____ Specialist: _____

Address: _____

Signature _____

Phone #: _____ Phone #: _____

Fax #: _____ Fax #: _____

Planned Date of Service: _____ Include LMP for OB requests _____

*****Always include relevant supporting clinical documentation including physician notes, lab results, radiology, etc as appropriate; this will better assist us in making a complete and timely review.*****

COVERAGE LIMITATIONS: Payment for services is limited to only those which are specifically authorized. If further diagnostic or therapeutic services are indicated an additional authorization is required. Referral Authorization is valid for time specified. Payment for services is contingent upon member eligibility at time of service.