PRIOR AUTHORIZATION FORM

Van Lang IPA,LLC
C/o MSO, Inc. of Southern California
2295 Huntington Drive, Suite D.
San Marino, CA 91108-2653
Telephone No: (626) 656-2370 Ext 122 & 128
Specialists: Please Fax Request To PCP

(Sections A - C must be filled out completely. Failure to complete these sections will delay the approval process.)

SECTION A PATIENT INFORMATION

Health Plan (Check One)**:** ☐ **AmeriGroup**

☐ **Need Culture & Linguistic Assistance**

Product / Service Line (Check One)**:** ☐ **Medicare Advantage** ☐ **Medi-Medi**

PATIENT/MEMBER **REFERRAL: / /2016**

Patient Accepted: ☐ **Yes** ☐ **No**

DOB: / / **GENDER:** ☐ F ☐ M

SECTION B PROVIDER INFORMATION

Please indicate whether the referral is to a participating or non-participating provider:
*(**NOTE**: Approval must be obtained **before appointment is scheduled**.) ☐ **Participating Provider** ☐ **Non-Participating**

REFERRED TO (PHYSICIAN/PROVIDER/FACILITY): **REFERRING PHYSICIAN** (PCP/PROVIDER):

☐ **Referred for Case Mgmt**

NAME: **PCP NAME:**

CHIP ☐ **Yes** ☐ **No**

SPECIALTY: dsadfa

ADDRESS: **ADDRESS:**

PHONE NO: **PHONE NO:**

FAX NO: **FAX NO:**

SECTION C REASON(S) FOR REFERRAL

Please select the appropriate referral type: **Urgent** (72 hours) ☐ **Routine** (14 Business days Medicare/5Business days) ☐ **Retro** (30 days)

ICD10-Code: **ICD10-Code:** **CPT CODE 1:** **CPT CODE 3:**

IDC10-Code: **IDC10-Code:** **CPT CODE 2:** **CPT CODE 4:**

☐ **Need Health Education**

Accident: **DX/Significant Reason(s) for Referral (Attach H&Ps, Progress Notes):**

☐ **Yes** ☐ **No**

PCP SIGNATURE: **DATE**

ATTENTION: PRIMARY CARE PHYSICIAN REFERRAL REVIEW and PROCESSING

Primary Care: Once you have received *or initiated* this authorization request and have reviewed attached supporting documentation, please indicate the following:

DOCUMENTATION REVIEW

☐ There is pertinent and timely documentation attached ☐ There **IS NOT** pertinent and timely documentation attached

PCP REVIEW

☐ I have reviewed this request and I recommend approval ☐ I have reviewed this request and **I DO NOT** recommend approval

☐ I would like to ask for a second opinion regarding

☐ As the PCP, I would like to reexamine this member to make further determination this request.

Please state your rationale for **NOT APPROVING** of this request:

After completion of your valued opinion, please proceed with filling out referral thru Riotap or by faxing request and all attached documentation to

(626) 248-9078

For processing and Medical Review.

IMPORTANT INSTRUCTIONS: TO CONSULTING PROVIDERS AND PCPS. PLEASE READ CAREFULLY.

- **Physician Reviewer is available to discuss the outcome of this authorization at (626) 656-2370 X122, 128**

Important Notice: Authorization Referral Form must include ICD-9 and CPT Codes; it will be returned for incompletion, delaying the approval process. **Documentation supporting medical necessity must accompany referral. If medical necessity cannot be established, referral may be denied.**

- **SPECIALIST:** If further diagnosis, therapeutic services or consults are indicated, contact the PCP for additional referral information and/or modification to services requested.
- This is not an authorization to admit the member to any inpatient facility. Please contact the PCP if hospitalization is needed. In the event eligibility has been terminated, this referral is no longer valid. **PROVIDERS SHOULD ALWAYS VERIFY ELIGIBILITY PRIOR TO RENDERING SERVICE(S) BY CALLING THE MEMBER'S HEALTH PLAN OR AEVS (for Medi-Cal managed care patients).**
- To insure prompt and accurate payment of your fees, attach one copy of this Authorization Referral Form and Progress Notes to your standard bill and send to the above address. **Do Not Bill The Patient/Member.**
- Your claim form must include the CPT Code with corresponding charges, DOS, and ICD-9 Diagnosis Code. **Incomplete Claims Will Be Deferred.**
- Services will be reimbursed according to the Provider Agreement, the patient's type of insurance coverage and/or UC&R. Rev 8.2012