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, 120, 128 & 131
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

REFERRAL DATE: / /2016 **Health Plan** ☐ **AmeriGroup/Anthem Blue Cross**

Patient Accepted: ☐ **Yes** ☐ **No**

Product / Service Line (Check One)**:** ☐ **Medicare Advantage** **NP10D0602513A5477777**

PATIENT/MEMBER NAME

☐ **Referred for Case Mgmt**

DOB: / / **GENDER:** ☐ F ☐ M

☐ **Need Culture & Linguistic Assistance**

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):
NAME:	**PCP NAME:**
SPECIALTY:	
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)

			units		units
ICD10-Code:	**ICD10-Code:**	**CPT CODE 1:**		**CPT CODE 3:**	
IDC10-Code:	**IDC10-Code:**	**CPT CODE 2:**		**CPT CODE 4:**	
IDC10-Code:	**IDC10-Code:**	**CPT CODE 5:**		**CPT CODE 6:**	

Accident?: ☐ **Yes** ☐ **No**

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

PROVIDER SIGNATURE: **DATE**

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-10 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.**
- 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-10 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