



Please consider using the web to submit your requests. To submit online, visit: <https://cencal.careportal.com>.

****If Urgent Please Call**

Referring Provider Information			
#1 Date request submitted:	MM / DD / YYYY	#2 Office contact person:	
#3 Provider Name:		#4 Physician Specialty:	
#5 Physician ID (NPI):		#6 Phone: (XXX) XXX - XXXX	#7 Fax: (XXX) XXX - XXXX
#8 E-mail Address:			

Rendering Facility/Practice Information			
#9 Facility/Practice Name:		#10 Facility/Practice Address:	
#11 Phone: (XXX) XXX - XXXX	#12 Fax: (XXX) XXX - XXXX	#13 Facility/Practice NPI#:	
#14 Member name:		#15 Date of Birth:	MM / DD / YYYY
#16 Member ID#:		#17 Member Phone #:	(XXX) XXX - XXXX

List procedure(s) Ordered

#18 Procedures	#19 CPT code	#20 Modifier	#21 Units

#22 Clinical indications for the ordered exams (e.g., signs, symptoms with severity and duration, working diagnosis)

THIS SECTION MAY BE ACCOMPANIED OR REPLACED BY A COPY OF MEDICAL NOTES AND/OR REPORTS OF RELEVANT IMAGING AND LAB STUDIES SUPPORTING THE MEDICAL NECESSITY FOR THE STUDY REQUESTED.

#23 Primary ICD-10 Code

Any relevant prior tests, treatments or other information

If our Physician Reviewer needs to contact the ordering provider, what is the best day, time and phone number?

#24 Days (circle):	M T W Th F	#25 Times:		#26 Phone:	(XXX) XXX - XXXX
#27 Requested by (print):		#28 Submission Date:			MM / DD / YYYY

#29 Referring Provider Signature:

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Instructions for Filling out Form Fields of Required Information

Field No.	Name	Description – Below contains a brief description. For more detailed information, see Provider Manual.
1.	<i>Date Request Submitted</i>	Date the Request form is being submitted – MM/DD/YYYY
2.	<i>Office Contact Person</i>	Person filling Prior Authorization Request Form or Name of Best Contact Person
3.	<i>Provider Name</i>	Referring/Ordering Provider's First & Last Name
4.	<i>Physician Specialty</i>	Referring/Ordering Provider's Specialty
5.	<i>Physician ID (NPI)</i>	Referring/Ordering Provider's NPI # - Mandatory
6.	<i>Phone</i>	Referring/Ordering Provider's Office Phone # - 1 (XXX) XXX-XXXX
7.	<i>Fax</i>	Referring/Ordering Provider's Office Fax # - 1 (XXX) XXX-XXXX
8.	<i>E-Mail Address</i>	Referring/Ordering Provider's Office E-Mail Address - Mandatory
9.	<i>Facility/Practice Name</i>	Rendering Facility/Practice Name Where Procedure Will Take Place
10.	<i>Facility/Practice Address</i>	Rendering Facility/Practice Address Where Procedure Will Take Place
11.	<i>Phone</i>	Rendering Facility/Practice Phone # - 1 (XXX) XXX-XXXX
12.	<i>Fax</i>	Rendering Facility/Practice Fax # - 1 (XXX) XXX-XXXX
13.	<i>Facility/Practice NPI #</i>	Insert Rendering Facility/Practice NPI#
14.	<i>Member Name</i>	Name of Member Procedure is Being Requested for
15.	<i>Date of Birth</i>	Date of Birth for the Member – MM/DD/YYYY
16.	<i>Member ID #</i>	Medicaid ID # of the Member
17.	<i>Member Phone #</i>	Best Contact Phone # for the Member - 1 (XXX) XXX-XXXX
18.	<i>Procedures</i>	Description or Modality of Procedure(s) Being Requested
19.	<i>CPT Code</i>	CPT Code Associated with Requested Procedure(s)
20.	<i>Modifier</i>	Body Modifier (i.e. Left, Right)
21.	<i>Units</i>	Number of Requested Units
22.	<i>Clinical Indications for the Ordered Exams</i>	Explained in Description, Option to Fill in Information Fields or Attach Clinical Notes
23.	<i>Primary ICD-9 Code</i>	Minimum of 1 Primary Diagnosis/ICD-10 Code Required with Each Requested CPT Code
24.	<i>Days (Circle)</i>	Best Day(s) Available to Reach Referring Physician – circle days
25.	<i>Times</i>	Best Time(s) of Day to Reach Referring Physician – (Note Program Open 5am-5pm PST)
26.	<i>Phone</i>	Best Phone # to Reach Referring Physician - 1 (XXX) XXX-XXXX
27.	<i>Requested by (Print)</i>	Printed Name of Referring/Ordering Provider
28.	<i>Submission Date</i>	Date the Prior Authorization Form is Being Submitted
29.	<i>Signature</i>	Signature of Ordering Provider

