



TREATMENT AUTHORIZATION FORM

- Medi-Cal Managed Care (SFHP: SF Health Plan)
 Healthy Families (SFHP) Other: _____

NEMS-MSO – 1520 Stockton Street, San Francisco, CA 94133 – Tel: (415) 352-5045 Fax: (415) 398-1742

Member Information	Name: _____ Date of Birth: _____ SFHP ID #: _____
PCP/Referring Provider	Name: _____ Phone #: _____ Fax #: _____
Specialist	Name: _____ Specialty: _____
	Contact Person: _____ Phone #: _____ Ext.: _____
	Address: _____ Fax #: _____

REQUESTED SERVICES

- | | | | |
|-------------------------|---|--|---|
| Type of Service: | <input type="checkbox"/> Consultation | <input type="checkbox"/> Ambulatory Surgery | <input type="checkbox"/> Physical / Occupational / Speech Therapy |
| | <input type="checkbox"/> Inpatient Services / SNF | <input type="checkbox"/> Home Health Services | <input type="checkbox"/> X-ray / CT / MRI / Imaging Studies |
| | <input type="checkbox"/> Audiology / Hearing Services | <input type="checkbox"/> Laboratory Studies | <input type="checkbox"/> Ultrasound |
| | <input type="checkbox"/> Cardiology | <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Other: _____ |

Diagnosis Description: _____ ICD-9: _____

For Completion by Referring Provider			For NEMS-MSO Use Only					
Specific Services Requested	Procedure Code (CPT code)	Units of Service	Auth. Y	Auth. N	Authorization Number	Approved Units	Approval Date	Exp. Date

Medical Justification: *(copy of related medical records/x-ray/lab reports - attach as necessary)*

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I certify that the above requests are medically necessary in the care of this patient.

Referring Provider Signature: _____ Date: _____

Important Note: Services which have not received an Authorization Number will not be paid. Authorization does not guarantee patient eligibility. To verify eligibility, call SFHP directly at (415) 547-7810.

For NEMS-MSO Use Only

- Approved Approved as Modified Below Denied Deferred

Comments:

By: _____ Date: _____ By: _____ Date: _____