TREATMENT AUTHORIZATION FORM

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

NEMS-MSO – 369 Broadway Street, San Francisco, CA 94133 – **Tel: (415) 352-5045 Fax: (415) 398-2895**

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:

☐ Consultation ☐ Ambulatory Surgery ☐ Physical / Occupational / Speech Therapy
☐ Inpatient Services / SNF ☐ Home Health Services ☐ X-ray / CT / MRI / Imaging Studies
☐ Audiology / Hearing Services ☐ Laboratory Studies ☐ Ultrasound
☐ Cardiology ☐ Durable Medical Equipment ☐ 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 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. Payment is contingent upon eligibility at the time of service. Providers are responsible for checking patient eligibility prior to rendering services. To verify eligibility, call SFHP directly at (415) 547-7810.*

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☐ **Approved** ☐ **Approved as Modified Below** ☐ **Denied** ☐ **Deferred**

Comments: .....

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