# NEW REFERRAL CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

## Provider Information

1. Date of request | 2. Provider name | 3. Medi-Cal provider number

4. Address (number, street) | City | State | ZIP code

5. Contact person | 6. Contact telephone number ( ) | 7. Contact fax number ( )

## Client Information

8. Client name—last | first | middle

9. Alias (AKA) | 10. Gender ☐ Male ☐ Female | 11. Date of birth (mm/dd/yy)

12. CCS/GHPP case number | 13. Contact phone number ( ) | 14. Medical record number (hospital or office)

15. Residence address (number, street) *(DO NOT USE P.O. BOX)* | City | State | ZIP code

16. Mailing address (if different) (number, street, P.O. box number) | City | State | ZIP code

17. County of residence | 18. Language spoken | 19. Name of parent/legal guardian

20. Mother's first name | 21. Primary care physician (if known) | 22. Primary care physician telephone number ( )

## Insurance Information

23.a. Enrolled in Medi-Cal? ☐ Yes ☐ No | 23.b. If yes, client index number (CIN) | 23.c. Client's Medi-Cal number

24. Enrolled in Healthy Families? ☐ Yes ☐ No | If yes, name of plan

25. Enrolled in commercial insurance plan? ☐ Yes ☐ No | If yes, type of commercial insurance plan ☐ PPO ☐ HMO ☐ Other | Name of plan

## Diagnosis

26.
Diagnosis (DX)/ICD-9: ____________ DX/ICD-9: ____________ DX/ICD-9: ____________

## Requested Services

| 27.* CPT-4/ HCPCS Code/NDC | 28. Specific Description of Service/Procedure | 29. From (mm/dd/yy) | To (mm/dd/yy) | 30. Frequency/ Duration | 31. Quantity | 32. Units of Service (Pharmacy Only) |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

* A specific procedure code/NDC is required in column 27 if services requested are other than ongoing physician authorizations or special care center authorizations to the bottom of column 29.

33. Other documentation attached ☐ Yes | 34. Enter facility name (where requested services will be performed, if other than office.

## Inpatient Hospital Services

35. Begin date | 36. End date | 37. Number of days

## Additional Services Requested from Other Health Care Providers

38. **Provider's name** | Medi-Cal provider number | Telephone number ( ) | Contact person

Address (number, street) | City | State | ZIP code

Description of services | Procedure code | Quantity

Additional information

39. **Provider's name** | Medi-Cal provider number | Telephone number ( ) | Contact person

Address (number, street) | City | State | ZIP code

Description of services | Procedure code | Quantity

Additional information

40. Signature of physician/provider or authorized designee | 41. Date

# NEW REFERRAL CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

## Provider Information

1. Date of request | 2. Provider name | 3. Medi-Cal provider number

4. Address (number, street) | City | State | ZIP code

5. Contact person | 6. Contact telephone number ( ) | 7. Contact fax number ( )

## Client Information

8. Client name—last | first | middle

9. Alias (AKA) | 10. Gender ☐ Male ☐ Female | 11. Date of birth (mm/dd/yy)

12. CCS/GHPP case number | 13. Contact phone number ( ) | 14. Medical record number (hospital or office)

15. Residence address (number, street) *(DO NOT USE P.O. BOX)* | City | State | ZIP code

16. Mailing address (if different) (number, street, P.O. box number) | City | State | ZIP code

17. County of residence | 18. Language spoken | 19. Name of parent/legal guardian

20. Mother's first name | 21. Primary care physician (if known) | 22. Primary care physician telephone number ( )

## Insurance Information

23.a. Enrolled in Medi-Cal? ☐ Yes ☐ No | 23.b. If yes, client index number (CIN) | 23.c. Client's Medi-Cal number

24. Enrolled in Healthy Families? ☐ Yes ☐ No | If yes, name of plan

25. Enrolled in commercial insurance plan? ☐ Yes ☐ No | If yes, type of commercial insurance plan ☐ PPO ☐ HMO ☐ Other | Name of plan

## Diagnosis

26.
Diagnosis (DX)/ICD-9: ____________ DX/ICD-9: ____________ DX/ICD-9: ____________

## Requested Services

| 27.* CPT-4/ HCPCS Code/NDC | 28. Specific Description of Service/Procedure | 29. From (mm/dd/yy) | To (mm/dd/yy) | 30. Frequency/ Duration | 31. Quantity | 32. Units of Service (Pharmacy Only) |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

* A specific procedure code/NDC is required in column 27 if services requested are other than ongoing physician authorizations or special care center authorizations to the bottom of column 29.

33. Other documentation attached ☐ Yes | 34. Enter facility name (where requested services will be performed, if other than office.

## Inpatient Hospital Services

35. Begin date | 36. End date | 37. Number of days

## Additional Services Requested from Other Health Care Providers

38. **Provider's name** | Medi-Cal provider number | Telephone number ( ) | Contact person

Address (number, street) | City | State | ZIP code

Description of services | Procedure code | Quantity

Additional information

39. **Provider's name** | Medi-Cal provider number | Telephone number ( ) | Contact person

Address (number, street) | City | State | ZIP code

Description of services | Procedure code | Quantity

Additional information

40. Signature of physician/provider or authorized designee | 41. Date