

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 <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		23.b. If yes, client index number (CIN)	23.c. Client's Medi-Cal number
24. Enrolled in Healthy Families? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, name of plan	
25. Enrolled in commercial insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. If yes, type of commercial insurance plan <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> 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 <input type="checkbox"/> Yes	34. Enter facility name (where requested services will be performed, if other than office).
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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
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24. Enrolled in Healthy Families? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, name of plan	
25. Enrolled in commercial insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. If yes, type of commercial insurance plan <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Other	Name of plan

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