

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

Provider Information

| | | |
|-----------------------------|------------------------------------|------------------------------|
| 1. Date of request | 2. Provider name | 3. 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. Medical record number (hospital or office) |
| 14. Home phone number () | |
| 15. Cell phone number () | 16. Work phone number () |
| 17. Email address | |
| 18. Residence address (number, street) (DO NOT USE P.O. BOX) City State ZIP code | |
| 19. Mailing address (if different) (number, street, P.O. box number) City State ZIP code | |
| 20. County of residence | 21. Language spoken |
| 22. Name of parent/legal guardian | |
| 23. Mother's first name | 24. Primary care physician (if known) |
| 25. Primary care physician telephone number () | |

Insurance Information

| | | |
|---|---|--------------------------------|
| 26.a. Enrolled in Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No | 26.b. If yes, client index number (CIN) | 26.c. Client's Medi-Cal number |
| 27. Enrolled in commercial insurance plan <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, type of commercial insurance plan <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Other | Name of plan |

Diagnosis

28. Diagnosis (DX)/ICD-10: _____ DX/ICD-10: _____ DX/ICD-10: _____

Requested Services

| 29.* CPT-4/ HCPCS Code/NDC | 30. Specific Description of Service/Procedure | 31. From (mm/dd/yy) | To (mm/dd/yy) | 32. Frequency/ Duration | 33. Units | 34. Quantity (Pharmacy Only) |
|----------------------------------|--|---------------------------|------------------|-------------------------------|--------------|------------------------------------|
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* A specific procedure code/NDC is required in column 27 if services requested are other than ongoing physician authorizations, hospital days, or special care center authorizations.

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| 35. Other documentation attached <input type="checkbox"/> Yes | 36. Enter facility name (where requested services will be performed, if other than office). |
|--|---|

Inpatient Hospital Services

| | | |
|----------------|--------------|--------------------|
| 37. Begin date | 38. End date | 39. Number of days |
|----------------|--------------|--------------------|

Additional Services Requested from Other Health Care Provider

| | | | | |
|--------------------------|--|-----------------|-------------------------|----------------|
| 40. Provider's name | | Provider number | Telephone number () | Contact person |
| Address (number, street) | | City | State | ZIP code |
| Description of services | | Procedure code | Units | Quantity |
| Additional information | | | | |

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not be processed.

| | |
|--|----------|
| 41. Signature of physician/provider or authorized designee | 42. Date |
|--|----------|

Instructions

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Provider number: Enter National Provider Identification (NPI) number (no group numbers).
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.

Client Information

8. Client name: Enter the client's name—last, first, and middle.
9. Alias (AKA): Enter the patient's alias, if known.
10. Gender: Check the appropriate box.
11. Date of birth: Enter the client's date of birth.
12. CCS/GHPP case number: Enter the client's California Children's Services (CCS)/Genetically Handicapped Persons Program (GHPP) number. If not known, leave blank.
13. Medical record number: Enter the client's hospital or office medical record number.
14. Home phone number: Enter the home phone number where the client or client's legal guardian can be reached.
15. Cell phone number: Enter the cellular phone number where the client or client's legal guardian can be reached.
16. Work phone number: Enter the work phone number where the client or client's legal guardian can be reached.
17. Email address: Enter the email address of the client or client's legal guardian.
18. Residence address: Enter the address of the client. Do not use a P.O. Box number.
19. Mailing address: Enter the mailing address if it is different than number 18.
20. County of residence: Enter residential county of the client.
21. Language spoken: Enter the client's language spoken.
22. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
23. Mother's first name: Enter the client's mother's first name.
24. Primary care physician: Enter the client's primary care physician's name. If it is not known, enter NK (not known).
25. Primary care physician telephone number: Enter the client's primary care physician phone number.

Insurance Information

- 26a. Enrolled in Medi-Cal? Mark the appropriate box. If the answer is yes, enter the client's index number in box 26.b. and the client's Medi-Cal number in box 26.c.
27. Enrolled in a commercial insurance plan? Mark the appropriate box, if the answer is yes, mark the type of insurance plan and enter the name of the commercial insurance plan on the line provided.

Diagnosis

28. Diagnosis and/or ICD-10: Enter the diagnosis or ICD-10 code, if known, relating to the requested services.

Requested Services

29. CPT-4/HCPCS code/NDC: Enter the CPT-4, HCPCS code or NDC code being requested. This is only required if services requested are other than ongoing physician authorizations or special care center authorizations. Also not required for inpatient hospital stay requests.
30. Specific description of procedure/service: Enter the specific description of the procedure/service being requested.
31. From and to dates: Enter the date you would like the services to begin. Enter the date you would like the services to end. These dates are not necessarily the dates that will be authorized.
32. Frequency/duration: Enter the frequency or duration of the procedures/service being requested.
33. Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
34. Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
35. Other documentation attached: Check this box if attaching additional documentation.
36. Enter facility name: Complete this field with the name of the facility where you would like to perform the surgery you are requesting.

Inpatient Hospital Services

37. Begin date: Enter the date the requested inpatient stay shall begin.
38. End date: Enter the end date for the inpatient stay requested.
39. Number of days: Enter the number of days for the requested inpatient stay.

Additional Services Requested from Other Health Care Providers

40. Provider's name: Enter name of the provider you are referring services to.
Provider number: Enter the provider's National Provider Identification (NPI) number. Telephone: Enter provider's telephone number.
Contact person: Enter the name of the person who can be contacted regarding the request. Address: Enter address of the provider.
Description of services: Enter description of referred services.
Procedure code: Enter the procedure code for requested service other than ongoing physician services.
Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
Additional information: Include any written instructions/details here.

Signature

41. Signature of physician or provider: Form must be signed by the physician, pharmacist, or authorized representative.
42. Date: Enter the date the request is signed.