

## ADMINISTRATIVE REFERRAL AUTHORIZATION FORM

Please Check one:

**PCP**                       **SPECIALIST**

Check ONE Program:

CareAdvantage     Medi-Cal  
 Health Families     Healthy Kids  
 HealthWorx

**Instructions for Physician Rendering the Services (see below)**

- 1) Please complete ALL FIELDS
- 2) Check Reason Below (1, 2, or 3)
- 3) Fax copy of the completed form to:  
 HPSM at 650-829-2079  
 URGENT FAX: 650-829-2021
- 4) Incomplete or illegible forms will be returned.

Reimbursement is limited to urgent care services and is subject to member and provider eligibility and review for medical justification.

This Administrative RAF is for (Please Check One):

- (1) **Urgent Care** services provided by any provider who is not the member's assigned PCP
- (2) **Specialist Services** provided within 3 days from an ER discharge
- (3) **Specialist Services** provided for a member residing in a LTC Facility
- Other \_\_\_\_\_

For Reason (1), Follow up visits must occur with the member's assigned PCP.

For Reason (2), additional visits will require a RAF issued by the member's assigned PCP.

Member's Assigned PCP Name

Member in LTC Facility

Member Name

Date of Birth

Member ID Number

Member Phone Number

Reason For Urgent Care / Pertinent Patient History

ER Follow Up

Date of ER visit

MEDI-CAL Provider Number

ICD-9-CM Diagnosis Code

**Attach clinical documentation to support request**

Provider Rendering Service

NPI #

Provider Address

Provider Phone Number

Provider Fax Number

Rendering Provider's Signature

Date

**HPSM USE ONLY**

Service Authorized for (Date)

RAF Number

HPSM R.N.'s or M.D.'s Signature

Date

**SERVICES NOT AUTHORIZED (CHECK ALL THAT APPLY)**

- Lack of medical justification for urgent care
- Requested service is for chronic / preventative care.
- Member not eligible with HPSM.
- Provider not eligible with HPSM.
- Other

**AUTHORIZATION NUMBER**