

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
- 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/ICD-10 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