TREATMENT AUTHORIZATION REQUEST - ATTACHMENT FORM

STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES

INTERNAL CONTROL NUMBER - FI USE ONLY

3

CONFIDENTIAL PATIENT INFORMATION PLEASE TYPE INFORMATION

## PART I: PROVIDER INFORMATION

1 SUBMITTING PROVIDER # | 2 PATIENT RECORD # | 3 PROVIDER PHONE # | 4 PROVIDER FAX #

5 PROVIDER NAME | 10 MEDICARE CERTIFIED

6 PROVIDER STREET/MAILING ADDRESS | 11 PROVIDER CONTACT NAME

7 CITY | 8 STATE (CA) | 9 ZIP CODE | 12 PROVIDER CONTACT PHONE #

13 ORIGINAL TAR NUMBER | 14 UPDATE RSN | 15 SPCL HNDLG | 16 RETRO RSN | 17 RETRO DATE

## PART II: PATIENT INFORMATION

31 MEDI-CAL IDENTIFICATION NUMBER | 32 PATIENT NAME, LAST | 33 FIRST | 34 SEX | 35 RES STAT | 36 WRC

TO THE BEST OF MY KNOWLEDGE, THE ABOVE IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

**SIGNATURE OF PHYSICIAN OR PROVIDER** **DATE**

X

Note: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.