



東北醫療中心

Management Services Organization (MSO)
 2171 Junipero Serra Boulevard, Suite 600
 Daly City, CA 94014
 Phone (415) 352-5186 Fax (415) 398-2895

TREATMENT AUTHORIZATION FORM

Type of Request:

Routine Urgent Retro

Member Information	Name: _____ Date of Birth: _____ Member ID #: _____
	Requesting Provider
Rendering Provider	Name: _____ Phone #: _____ Fax #: _____
	Provider Name: _____ NPI: _____ Specialty: _____
	Facility: _____ Contact Person: _____ Phone #: _____ Address: _____ Fax #: _____

Diagnosis Description 1: _____ ICD-10: _____ Diagnosis Description 2: _____ ICD-10: _____ Diagnosis Description 3: _____ ICD-10: _____ Diagnosis Description 4: _____ ICD-10: _____	Type of Service: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Office <input type="checkbox"/> DME <input type="checkbox"/> Home <input type="checkbox"/> Other: _____ Date of Service: _____
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For Completion by Referring Provider					
Specific Services Requested	Procedure Code (CPT code)	Units of Service	Specific Services Requested	Procedure Code (CPT code)	Units of Service
1.			4.		
2.			5.		
3.			6.		

Medical Justification: *(copy of related medical records/x-ray/lab reports - attach as necessary)*

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I certify that the above requests are medically necessary in the care of this patient.

Referring Provider Signature: _____ **Date:** _____

Important Note: Payment is contingent upon eligibility at the time of service. Providers are responsible for checking patient eligibility prior to rendering services by verifying eligibility directly with member's health plan. Payment to non-contracted/out-of-network providers is based on the current CMS Medicare or DHCS Medi-Cal fee schedule according to member's eligibility at the time of service.

For NEMS-MSO Use Only			
<input type="checkbox"/> Approved	<input type="checkbox"/> Modified	<input type="checkbox"/> Denied	<input type="checkbox"/> Deferred
Comments:			
By: _____		Date: _____	Date faxed: _____