CHILDREN FIRST MEDICAL GROUP

Instructions for Completing Request for Authorization Form

CFMG Section: To be completed by CFMG Provider

1. Authorization number is entered by CFMG following review for the approval or denial.
2. **URGENT BOX** – Check if services are required **within 72 hours**.
3. Member's name.
4. Member's birth date.
5. Member's address.
6. Member's identification number with dependent code.
7. Check appropriate box if work or accident related.

7A. Note other insurance coverage.

8. Referring Physician's name.
9. Referring Physician's address.
10. Referring Physician's phone/fax numbers.
11. Office contact person.
12. Full name of the specialist/facility (e.g. diagnostic facility, hospital, surgery center, physical therapist or home health agency).

12A. Address and telephone/fax number of the referral provider.

13. Office contact person.
14. Medical problem/diagnosis/date of onset/ICD-10 code.
15. Relevant clinical information (attach relevant chart notes, including prior consults, lab and x ray results).
16. Treatment rendered to date for this diagnosis/condition.
17. Specify reason for request.
18. Specify Procedure or Treatment requested and CPT code.
19. Check the appropriate box to indicate type of request, if initial or extension of a request, and the requested time frame for authorization.
20. Check **CONFIDENTIAL BOX** only in situations when it would not be appropriate to send copy of form to Member. CFMG will not mail notification to member. Primary Care Physician will notify Member.
21. The signature of the Referring Physician and date is required.

CFMG Section: To be completed by CFMG staff

1. Approval or denial, and extent of services authorized by approved referral provider will be noted.
2. Eligibility, Health Plan, ID#, effective and term date will also be indicated.
3. CFMG Chief Medical Officer signature and date.
4. An authorization notification letter will be mailed to the Primary Care Physician, Referral Specialist, Facility and Member.