REQUEST FOR AUTHORIZATION

6425 Christie Ave Ste 110
Emeryville CA 94608
TEL: 510-428-3489
FAX: 510-450-5868

Authorization Number

☐ URGENT (only check URGENT if member faces serious threat to their health or the non-urgent timeframe(5 day) would be a threat to the members health) DO NOT SCHEDULE WITHOUT AUTHORIZATION

ALL SECTIONS MUST BE COMPLETED TO ALLOW PROCESSING

Patient Name Last	First	MI	Birthdate (mmddyyyy)
New Address			Telephone
ID Number	☐ Work Related ☐ Auto Accident	☐ Other Insurance Describe	

FROM		REFERRAL TO	
Primary Care Physician / Specialist		Specialist / Facility	
Address		Address	
City / State / Zip		City / State / Zip	
Telephone	Fax	Telephone	Fax
Contact Person		Contact Person	
Diagnosis		Date Onset/Injury (mmddyyyy)	ICD-10:

Relevant Clinical Information (may attach pertinent chart notes)

Treatment to Date

Reason for Request

Procedure or Treatment Requested	CPT

Request(s)	Please specify in section above		Status of Request
☐ Evaluation only	☐ Diagnostic Test	☐ DME	☐ This is an initial request
☐ Treatment Procedure	☐ Physical Therapy		☐ This is an extension
☐ Home Health Services	☐ Other		☐ This is a retroactive request DOS:

Requested Number _____ ☐ Visit(s) over Number _____ ☐ Week(s)
☐ Treatment(s) ☐ Month(s)

☐ CONFIDENTIAL – DO NOT SEND TO MEMBER

PHYSICIAN SIGNATURE X	DATE

CFMG RESPONSE

APPROVED REQUESTS	ELIGIBILITY
Referral approved for:____________________	Health Plan: ____________________
Comments: ____________________	ID #: ____________________
	Eff Date:____________ Term Date: ____________

MEDICAL DIRECTOR SIGNATURE X	DATE

Payment is subject to verification of eligibility at the time of service. This authorization is valid for 90 days from the date of approval unless otherwise instructed.

(Rev 08/2023)

FAX TO CFMG 510-450-5868