6425 Christie Ave., Ste 110
Emeryville, CA 94608

CHILDREN FIRST MEDICAL GROUP

Secure email:CFMGUM@ucsf.edu
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** ☐ **Other Insurance** ☐ **Auto Accident** **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 04/2025)