Scripps | Health Plan Services

DATE OF REQUEST: _____

EMERGENT **( ) (858) 260-5870**
ROUTINE ( ) (858) 260-5861

AUTHORIZATION REQUEST FORM

Patient Identification:

Name: _____ MRN: _____ DOB: _____

Health Plan: _____ PCP: _____

Requesting MD: _____ Contact Name: _____
(at requesting office)

Requestor's Phone #: ( ) _____

Fax #: ( ) _____ **FAX TO: Intake Line (858) 260-5861**

Service Request:

Check One

( ) Consult / Office Visit / MD
( ) Diagnostic Test
( ) DME, Orthotic / Prosthetic
( ) **Home Health****
( ) Outpatient Surgery
( ) Inpatient Admission
( ) **PT, OT, Speech**
( ) **Therapy**** Other (specify)

** ___**# VISITS REQUESTED**

Provider Name: _____ Facility: _____

Diagnosis: 1) _____
2) _____
ICD-10 Code _____
ICD-10 Code _____

Description 1) _____
2) _____
CPT Code _____
CPT Code _____

Clinical Summary / Reason for Request:

_____

Fax to: Scripps Health Plan Services (858) 260-5861
For Information: Contact Customer Service (888) 680-2273