IMPERIAL HEALTH HOLDINGS
MEDICAL GROUP

PRE-AUTHORIZATION/REFERRAL AUTHORIZATION REQUEST FORM

Fax completed authorization request to: **(626) 364-0329/Toll Free Fax: (877) 233-5843** or call **(626) 838-5100/ Toll Free call 800-497-5509** for outpatient or inpatient requests.

☐ Standard ☐ Urgent/Expedited ☐ Retro **DATE OF SERVICE:** _____

Requesting Provider: _____ **Phone #:** _____ **Fax #:** _____

OFFICE: ☐ **OUTPATIENT:** ☐ **HOME HEALTH:** ☐ **DME:** ☐ **INPATIENT:** ☐ **SCHEDULED DATE OF SERVICE REQUESTED:** _____

Patient Name (full name) _____

Member ID# _____ **Date of Birth** _____

PCP Name _____ PCP **Phone #** _____ **Date Submitted**_____

Requested Service(s)

***Please list all CPT codes requested, please, no code ranges.**

CPT/Procedure code/# of units: _____ **Procedure description:** _____

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CPT/Procedure code/# of units: _____ **Procedure description:** _____

Diagnosis

ICD code(s): _____ **Diagnosis description:** _____

ICD code(s): _____ **Diagnosis description:** _____

ICD code(s): _____ **Diagnosis description:** _____

Requested Specialist/Provider

Specialist/Provider Name Referring to: _____

Specialist/ Provider Fax #: _____ **Specialist/ Provider Phone #:** _____

Specialist/ Provider Tax ID#: _____ **Specialist/ Provider Specialty**: _____

Requested Facility

Facility Referring to: _____ **Facility Phone #** _____

Facility Tax ID# _____

Please Attach Supporting Clinical/Therapy Indications:

***For continued stay review, contact us at (800) 497-5509 or fax to (626) 364-0329.**

This Referral Form does not guarantee payment by IHHMG or the Health Plan. Responsibility for payment shall be subject to membership eligibility, benefit limitations, and the interpretation of benefits under applicable subrogation and coordination of benefits rules. As the Primary Care Physician (PCP), I am referring this patient to you for the above treatment. For any other services it will be necessary to obtain an additional referral authorization.