

# Exclusive Care

## Medical Management

P.O. Box 1508, Riverside CA 92502-1508 - Office 877-755-0033 Fax 951-955-0035

[www.exclusivecare.com](http://www.exclusivecare.com)



**Chart notes and all diagnostic results MUST be attached.**

**\*\*PLEASE VERIFY ELIGIBILITY AT TIME OF SERVICE\*\***

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Member ID#: \_\_\_\_\_ DOB: \_\_\_\_\_ City \_\_\_\_\_ Phone #: \_\_\_\_\_

Referring Provider: name, address, phone & fax number		Request Provider or facility: address, phone & fax number	
Physician Signature		Office Contact: name, number	
Diagnosis:	ICD-9 Code:	CPT Code:	

**Outpatient ( )    Outpatient Surgery ( )    Inpatient ( )    \_\_\_\_\_ Day(s)**

Consult Only	Consult & 2 FUs	Add FU(s) to Control No. _____	Visits Used _____	Extended Date
Allergy	Audiology	Cardiology	Chiropractor	Dermatology    Diagnostic    DME
ENT	Endocrinology	Gastroenterology	Infertility	Nephrology    Neurology    Oncology
OB/Gynecology	Ophthalmology	Orthopedic	Pain Management	PT/OT/ST    Podiatry    Pulmonary
Radiology	Rheumatology	Sleep Study	Surgery	Urology    Vascular    VNA

Procedure \_\_\_\_\_

Medical Management use only

Added CPT Codes   
  Chart Notes   
  Guidelines   
  Medical Review  
 Member Terminated   
  Redirected   
  Non Covered Service   
  Direct Referral

Comments \_\_\_\_\_

**Approved** \_\_\_\_\_ Date \_\_\_\_\_   
 **Denied** \_\_\_\_\_ Date \_\_\_\_\_   
 **Pending** \_\_\_\_\_ Date \_\_\_\_\_

Authorized Signature	Control Number
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**APPROVED REFERRAL DOES NOT GUARANTEE PAYMENT,  
AUTHORIZATION IS VALID FOR 90 DAYS FROM APPROVAL DATE**