The Exclusive Health Plan Provider of the County of Riverside

Exclusive Care

Medical Management

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

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 FU's** ☐**Add FU(s) to Control No.** _____

☐Allergy ☐Audiology ☐Cardiology ☐Dermatology ☐Diagnostic ☐DME ☐ENT

☐Endocrinology ☐Gastroenterology ☐Infertility ☐Nephrology ☐Neurology ☐Neurosurgery

☐Oncology Orthopedic ☐Ophthalmology ☐Pain Mgmt ☐PT/OT/ST ☐Podiatry ☐Pulmonary

☐Radiology OB/Gynecology ☐Rheumatology ☐Sleep Study ☐Surgery ☐Urology

☐Vascular ☐VNA ☐Nutritional Consult ☐Physical Fitness Consult

Procedure_____

UR Use Only

☐Added CPT/FU ☐Request Chart Notes ☐Direct Referral

☐Medical Review ☐Member Terminated ☐Non-Covered Svc ☐Redirected ☐Appropriate Forms

☐Does Not Meet Medical Necessity Criteria

Comments_____

_____

Approved_____ Date **Denied**_____ Date **Pending** _____ Date

Authorized Signature	Control Number

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