



Medical Management

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Chart notes and all diagnostic results MUST be attached.

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

Patient Name: _____ Date: _____

Member ID#: _____ DOB: _____ City _____

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

Date of Service _____ Outpatient () Outpatient Surgery () Inpatient () _____ Day(s)

Consult Only	Consult & 2 FUs	Add FU(s) to Control No. _____		Visits Used _____	Status of Referral		
Allergy	Audio	Cardio	Chiro	Derm	DME	Endo	ENT
GI	Nephro	Neuro	Gyn	Onc	Ophth	Ortho	Pain Mgmt
PT/OT/ST	Podiatry	Pulm	Rad	Rheum	Sleep Study	Surg	Uro

Procedure _____

Medical Management use only

- | | | | |
|---------------------|---------------------|--------------------|-------------------------|
| ___ Added CPT Codes | ___ Chart Notes | ___ Extended Dates | ___ Medical Review |
| ___ Added Follow up | ___ Duplicate | ___ LOD Guidelines | ___ Member Terminated |
| ___ Redirected | ___ Added Procedure | ___ EAP | ___ Non Covered Service |
| ___ Direct Referral | Other _____ | | |

Approved _____ **Denied** _____ **Pending** _____
Date Date Date

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