



Authorization Department
 Phone: (714) 634-5169
 Faxes: (714) 634-9655 (714) 978-2367



Medical Services Initiative Referral Request

Patient Information

Last Name _____ First Name _____ Middle Initial _____

Member ID # _____ Date of Birth _____ Age _____ Male _____ Female _____

Phone _____ Address _____

Medical Information

Services requested: (consultation, Rx, etc.) _____

CPT Code(s) _____

All lab services must go through Quest. No PA required.

Diagnosis: _____ ICD 9 Code(s) _____

Radiology Procedures Requiring Prior Auth:

- CT/MRI/MRA Scans* PET* PET/CT* Dexascan
 Angiograms Biopsies Other Than Breast Nuclear Scans except cardiac

**Capitated with West Coast Radiology. All radiological services may also be provided by a network hospital.*

Symptoms _____

The following must support your request: Past clinical history, findings, evaluation, lab, radiology & consultation reports.

Requesting Physician Name _____ Phone _____

Contact Name _____ Fax _____

Specialist Name _____ Address _____

Phone _____ Fax _____

Please note that eligibility is not a guarantee of benefit. Always verify eligibility at: www.ocmsipov.com.

FOR COUNTY MSI USE ONLY

Referral Status: *Note: Response will be received within 5 business days for non urgent referrals.*

Date Request Received by UMD _____

Approved as Requested _____ Approved/Modified _____

Tracking Number _____ (Note: Tracking number does not guarantee payment.) Date _____
Tracking number must be included in Box 23 of the claim.

Request Denied _____ Reason _____

Specialists Name _____ Phone _____ Fax _____

DENIAL APPEAL/SECOND LEVEL REVIEW

Appeal Approved as Requested _____ Appeal Approved as Modified _____

Appeal Denied _____