



MEDICAL SERVICES INITIATIVE REFERRAL REQUEST
Authorization Department
Phone: (714) 784-4711 Fax: (714) 784-7475

Today's Date: _____

Priority Status: [] Routine [] Urgent

Patient Name _____
MSI ID# or SSN# _____
Date of Birth: ____/____/____
Month / Day / Year
Address: _____
Phone: (____) _____
Area Code Phone Number

Primary Care / Clinic Medical Home:

Requesting Physician:

Referred to Specialty: _____
Phone: (____) _____
Area Code Phone Number
Fax: (____) _____
Area Code Phone Number
Contact person: _____

Radiology Services Requiring Prior Authorization:

CT/MRI/MRA Scans *, PET*, PET/CT*, 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.

MEDICAL INFORMATION

Requested Service: _____ CPT Code(s): _____

Place of Service: _____ [] Office [] Outpatient [] Inpatient

Diagnosis: _____ ICD9 Code(s) _____

Description of Clinical History: _____

**Please include supporting clinical documentation. Referral must be complete to avoid delay in services. Authorization is not a guarantee of payment, patient must be eligible at the time of service. Please verify eligibility at www.ocmsipov.com