MEDICAL SAFETY NET (MSN) PROGRAM REFERRAL REQUEST
Care Coordination Unit
Phone: (714) 834-3557 Fax: (714) 564-0959

Today's Date: ______________ **Priority Status:** [ ] **Routine** [ ] **Urgent**

Patient Name: ____

MSN ID# or SSN#_____________________________

Date of Birth: ______/_____/_______ **Month / Day / Year**

Address: ____

Phone: (______) __________________

Assigned Community Clinic: ____

Requesting Physician: ____

Phone: (______) __________________ **Contact person** _______________________

Fax: (______) __________________

Requested Specialty/Service: ____________________________________

Address: (if known) ____

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Radiology Services Requiring Prior Authorization:
CT/MRI/MRA Scans, PET, PET/CT*, Angiograms, Biopsies other than breast, Nuclear Scans except cardiac.

MEDICAL INFORMATION

Requested Service: ____

CPT Code(s): ________ ________ ________ ________ ________ ________ ________

Place of Service: ___________________________________ [ ] **Office** [ ] **Outpatient** [ ] **Inpatient**

Diagnosis: ____

ICD10 Code(s) ________ ________ ________ ________ ________ ________ ________

Description of Clinical History: ____

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***Please include supporting clinical documentation. MSN Referral Request Form 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.ocmsnpov.com**.