ADVANCED MEDICAL MANAGEMENT, INC.
Phone 877-589-6807 Fax 562-766-2001

COUNTY MEDICAL SERVICES PROGRAM

Date of Request: __________ ☐ ROUTINE ☐ URGENT ☐
RETRO DOS__________

TREATMENT AUTHORIZATION REQUEST

PATIENT INFORMATION	TYPE OR PRINT LEGIBLY
Name:	**Member ID:**
Address:	**Phone:**
City,St,Zip:	**DOB:**
Requesting Specialist: **Phone #:** **Fax #:**	**Tax ID:** **NPI:**
Requested Specialist: **Phone #:** **Fax #:**	**Tax ID:** **NPI:**

MEDICAL INFORMATION	TYPE OR PRINT LEGIBLY
Facility:	**Diagnosis Description:** **ICD-10:**
Services Requested: All requests must include ALL CPT codes. ***INCOMPLETE REQUESTS WILL NOT BE PROCESSED***. ___ Initial Consult CPT __________ ___ Follow –up CPT ____________ ___ DME: CPT ________________ ___ Surgery: CPT_______________ ___ Diagnostic Radiology: CPT ______________ ___ Other Service: CPT__________	**Location:** Check One ☐ Office ☐ Home ☐ Outpatient Hospital ☐ Inpatient Hospital ☐ Other: _____________________

Clinical History and Findings: TYPE OR PRINT LEGIBLY

Please document below or attach last visit notes and any pertinent lab or x-ray results.

PLEASE NOTE THAT INCOMPLETE REQUESTS WILL NOT BE PROCESSED.

UTILIZATION REVIEW COMMITTEE

This authorization is based on medical necessity only and will be contingent upon eligibility and benefits. This is not a guarantee of payment. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing. Some CMSP recipients must fulfill their share of cost before services can be eligible for payment. Please call the number at the top of this form if this member has any additional medical or behavioral health needs.

OFFICE USE ONLY

Approved: Yes ☐ No ☐ ____ Expires: ____________ Authorization Number: ____________

Comments: ______________________________

Representative Name ____________________ Nurse Reviewer: ____________________