NEW REFERRAL CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request	2. Provider name	3. Provider number

4. Address (number, street) | City | State | ZIP code

5. Contact person	6. Contact telephone number	7. Contact fax number
	( )	( )

Client Information

8. Client name—last | first | middle

9. Alias (AKA)	10. Gender ☐ Male ☐ Female	11. Date of birth (mm/dd/yy)

12. CCS/GHPP case number	13. Contact phone number	14. Medical record number (hospital or office)
	( )	

15. Residence address (number, street) *(DO NOT USE P.O. BOX)* | City | State | ZIP code

16. Mailing address (if different) (number, street, P.O. box number) | City | State | ZIP code

17. County of residence	18. Language spoken	19. Name of parent/legal guardian

20. Mother's first name	21. Primary care physician (if known)	22. Primary care physician telephone number
		( )

Insurance Information

23.a. Enrolled in Medi-Cal? ☐ Yes ☐ No	23.b. Client index number (CIN)	23.c. Client's Medi-Cal number

24. Enrolled in Healthy Families? ☐ Yes ☐ No	If yes, name of plan

25. Enrolled in commercial insurance plan? ☐ Yes ☐ No	If yes, type of commercial insurance plan ☐ PPO ☐ HMO ☐ Other	Name of plan

Diagnosis

26. Diagnosis (DX)/ICD-9:_____ DX/ICD-9:_____ DX/ICD-9:_____

Requested Services

27.* CPT-4/ HCPCS Code/NDC	28. Specific Description of Service/Procedure	29. From (mm/dd/yy)	To (mm/dd/yy)	30. Frequency/ Duration	31. Units	32. Quantity (Pharmacy Only)

* A specific procedure code/NDC is required in column 27 if services requested are other than ongoing physician authorizations, hospital days, or special care center authorizations.

33. Other documentation attached ☐ Yes	34. Enter facility name (where requested services will be performed, if other than office).

Inpatient Hospital Services

35. Begin date	36. End date	37. Number of days

Additional Services Requested from Other Health Care Providers

38. **Provider's name** | Provider number | Telephone number ( ) | Contact person

Address (number, street) | City | State | ZIP code

Description of services	Procedure code	Units	Quantity
Diagnostic Audiologic Evaluation	**SCG 04**		

Additional information

39. **Provider's name** | Provider number | Telephone number ( ) | Contact person

Address (number, street) | City | State | ZIP code

Description of services	Procedure code	Units	Quantity
Otolaryngology Evaluation	**SCG 01**		

Additional information

40. Signature of physician/provider or authorized designee	41. Date

Instructions

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Medi-Cal provider number: Enter Medi-Cal billing number (no group numbers).
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.

Client Information

8. Client name: Enter the client's name—last, first, and middle.
9. Alias (AKA): Enter the patient's alias, if known.
10. Gender: Check the appropriate box.
11. Date of birth: Enter the client's date of birth.
12. CCS/GHPP case number: Enter the client's CCS/GHPP number. If not known, leave blank.
13. Contact phone number: Enter the phone number where the client or client's legal guardian can be reached.
14. Medical record number: Enter the client's hospital or office medical record number.
15. Residence address: Enter the address of the client. Do not use a P.O. Box number.
16. Mailing address: Enter the mailing address if it is different than number 15.
17. County of residence: Enter residential county of the client.
18. Language spoken: Enter the client's language spoken.
19. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
20. Mother's first name: Enter the client's mother's first name.
21. Primary care physician: Enter the client's primary care physician's name. If it is not known, enter NK (not known).
22. Primary care physician telephone number: Enter the client's primary care physician phone number.

Insurance Information

23a. Enrolled in Medi-Cal? Mark the appropriate box. If the answer is yes, enter the client's index number in box 23.b. and the client's Medi-Cal number in box 23.c.
24. Enrolled in Healthy Families?: Mark the appropriate box. If the answer is yes, enter the name of the plan.
25. Enrolled in a commercial insurance plan? Mark the appropriate box, if the answer is yes, mark the type of insurance plan and enter the name of the commercial insurance plan on the line provided.

Diagnosis

26. Diagnosis and/or ICD-9: Enter the diagnosis or ICD-9 code, if known, relating to the requested services.

Requested Services

27. CPT-4/HCPCS code/NDC: Enter the CPT-4, HCPCS code or NDC code being requested. This is only required if services requested are other than ongoing physician authorizations or special care center authorizations. Also not required for inpatient hospital stay requests.
28. Specific description of procedure/service: Enter the specific description of the procedure/service being requested.
29. From and to dates: Enter the date you would like the services to begin. Enter the date you would like the services to end. These dates are not necessarily the dates that will be authorized.
30. Frequency/duration: Enter the frequency or duration of the procedures/service being requested.
31. Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
32. Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
33. Other documentation attached: Check this box if attaching additional documentation.
34. Enter facility name: Complete this field with the name of the facility where you would like to perform the surgery you are requesting.

Inpatient Hospital Services

35. Begin date: Enter the date the requested inpatient stay shall begin.
36. End date: Enter the end date for the inpatient stay requested.
37. Number of days: Enter the number of days for the requested inpatient stay.

Additional Services Requested from Other Health Care Providers

38. and 39. Provider's name: Enter name of the provider you are referring services to.
Medi-Cal provider number: Enter the provider's Medi-Cal provider number.
Telephone: Enter provider's telephone number.
Contact person: Enter the name of the person who can be contacted regarding the request.
Address: Enter address of the provider.
Description of services: Enter description of referred services.
Procedure code: Enter the procedure code for requested service other than ongoing physician services.
Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
Additional information: Include any written instructions/details here.

Signature

40. Signature of physician or provider: Form must be signed by the physician, pharmacist, or authorized representative.
41. Date: Enter the date the request is signed.