**Treatment Authorization Form**

**If you need access to the referral management system, Epic Link, please visit** [**www.hoag.org/hpp**](http://www.hoag.org/hpp) **for Epic Link portal sign up and training.**

**If you cannot locate the patient on Epic Link, please fax treatment authorization form to the Hoag Clinic Enrollment Team at 949-791-3529 or e-mail this form to Eligibility@hoag.org.**

**Eligibility must be confirmed with the health plan within 2 business days prior to providing the service. Documented proof of verification of eligibility (i.e. print screen from on-line verification or faxed confirmation from health plan)** **may be required for payment.**

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| --- | --- | --- | --- | --- |
| **PATIENT INFORMATION** | | | | |
|  |  |  |  |  |
| **PATIENT’S FIRST NAME** | **PATIENT’S LAST NAME** | **AGE** | **SEX** | **DATE OF BIRTH** |
|  |  |  |  |  |
| **PATIENT ADDRESS** | **CITY** | **ZIP** | **PHONE** | **PCP** |
|  | |  |  | |
| **HEALTH PLAN** | | **MEMBER ID** | **MEMBER EFFECTIVE DATE** | |
|  |  |  |  |  |
| **EPIC MRN** (IF APPLICABLE) | **IS PRESENT PROBLEM DUE TO:** | **ACCIDENT AT WORK** | **AUTO ACCIDENT** | **If yes, DATE OF INJURY:** |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **REQUEST FROM** | | | | | | | | | | | |
|  | | |  | | | | |  | |  | |
| **REQUESTING PROVIDER NAME** | | | **REQUESTING PROVIDER SIGNATURE** | | | | | **PHONE NUMBER** | | **FAX NUMBER** | |
| **REQUEST TO** | | | | | | | | | | | |
|  | | | |  | | | | | | | |
| **REQUESTED PROVIDER NAME** | | | | **REQUESTED PROVIDER SPECIALITY and CONTACT INFORMATION** | | | | | | | |
|  | | | | **Office / Affiliated Rad (11)** | | | **Hoag Rad / Outpatient Surgery (22)** | | **Ambulatory Surgery Center (24)** | | |
| **REQUESTED FACILITY INFORMATION** | | | |
| **SERVICES REQUESTED** | | | | |  | **DIAGNOSIS CODES** | | | | |
| **CPT CODE** | | **UNITS** | | |
| **1** |  |  | | | **1** |  | | | | |
| **2** |  |  | | | **2** |  | | | | |
| **3** |  |  | | | **3** |  | | | | |
| **4** |  |  | | | **4** |  | | | | |
| **5** |  |  | | | **5** |  | | | | |
| **6** |  |  | | | **6** |  | | | | |

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| **Attach this form and send to: Hoag Clinic UM Team** | | | |
| **Phone Number:** | 949-791-3490 | | |
| **Routine Fax:** | 949-791-3491 | **Urgent Fax:** | 949-791-3492 |
| **Address:** | Hoag Clinic PO Box 3499 Costa Mesa CA 92628 | | |

**NOTE: In-Network providers are encouraged to use Epic Link to submit and check the status of a prior – authorization requests. Providers are expected to attach the necessary clinical records or supporting documentation for this request.**