CHAMPION

Authorization Service Request Form

Tel: (949) 850-3365 | Fax: (949) 850-2542

Request Type: ☐ Expedited (Urgent) ☐ Standard (Routine)

PATIENT INFORMATION

Patient Name	DOB	Member ID		
Address	City	State	Zip	
Phone #	Gender ☐ Male ☐ Female			

PROVIDER / REFERRAL INFORMATION

Referring to	Specialty	Phone
Address		Appt. Date & Time
PCP Signature	PCP Name	Today's Date

REFERRAL POLICY

- Please submit consult notes and, if applicable, any labs, X-rays, or other clinical notes with this form.
- For DME or Home Health, please provide duration & frequency.

Diagnosis: _____

ICD-10: _____

_____

_____

_____

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SERVICES REQUESTED

Service Requested: _____

CPT/HCPCS: _____

Service Requested: _____

CPT/HCPCS: _____

Service Requested: _____

CPT/HCPCS: _____

Service Requested: _____

CPT/HCPCS: _____

SETTING & FACILITY

☐ **INPATIENT** ☐ **OUTPATIENT SERVICES**

Facility: _____

OFFICE CONTACT

Office contact: _____

Phone: _____ **Fax:** _____