AUTHORIZATION REFERRAL FORM

765 THE CITY DRIVE SOUTH, #150 ORANGE, CA 92868
PHONE: (949) 393-8871 FAX: (714) 908-8055

☐ **STANDARD** (Part C decision time: 7 calendar days, Part B: 72 hours.)

☐ **EXPEDITED** (Part C decision time: 72 hours, Part B: 24 hours) ***(Please only mark as EXPEDITED if delay could harm the beneficiary's life, health, or ability to regain maximum function.)***

Date:	**Member:**	**DOB:**	**Male/Female**
Member's Address:			
Phone:	**Member ID:**	**ICD-10 Diagnosis:**	
Referring Provider:		**Phone:**	**Fax:**
NPI:		**Tax ID:**	

Referral Instructions:

Please return all completed fields and medical records in support of this referral to Avanta Medical IPA UM Department (714) 908-8055.

Requested Provider:	**Specialty:**	**Contracted?** ***If no, please include a copy of the provider's W-9 form for processing.*** ☐Yes ☐No	
Address:		**Phone:**	**Fax:**
NPI:	**Tax ID:**	**Place of Service:**	
CPT Codes:		**Services Requested:**	
Information for Referral:			
Requesting Provider's Signature:		**Date:**	

If the physician would like to discuss this case with the Medical Director or would like a copy of the criteria used to make decisions, please call the listed number of your decision sheet. AUTHORIZATION IS CONTINGENT UPON MEMBER'S ELIGIBILITY ON THE DATE OF SERVICE. Do not schedule non-emergent services until authorization is obtained.