PacifiCare®
SecureHorizons®

ROUTINE ☐ URGENT ☐ STAT ☐

TREATMENT AUTHORIZATION FORM

Prior Auth. Fax #	(800) 457-3828
Home Health Auth. Fax #	(800) 207-1833
DME Auth. Fax #	(800) 710-8812

PLAN TYPE: ☐ Commercial ☐ Secure Horizons

From:
Name:
Address:
City, State, Zip:
Phone:
Fax Back No.:

THIS PORTION TO BE COMPLETED BY PHYSICIAN

Patient Name:			Primary Care MD:		
Address:			Refer To:		
City:		State:	Specialty:		
Zip:	Home #:		Address:		
Sex:	DOB:	Age:	City:	State:	Zip:
Member ID#:			Office #:	Office Fax #:	

Type of Service: Inpatient ☐ Outpatient ☐ Home Health ☐ DME ☐ Initial Visit ☐ Return Visit ☐ Other _____

CLINICAL HISTORY & PHYSICAL FINDINGS

REASON FOR REFERRAL: Consultation ☐ Testing ☐ Follow-up ☐ Procedure ☐ **No. of Visits Requested:** _____

DIAGNOSIS	ICD-9 CM CODE:
1.	
2.	
EVALUATION & TREATMENT PLAN	**RVS/CPT – 4 CODE:**
1.	
2.	
3.	

REQUESTED FACILITY

Accident: Yes ☐ No ☐ Occurrence: Home ☐ Work ☐ Auto ☐ Other ☐

Other Insurance: _____

MD Signature: _____ Date: _____

**** NOTE: The member has the right to appeal denial of services through PacifiCare/Secure Horizons*

THIS PORTION TO BE COMPLETED BY UR ONLY. THIS REFERRAL FORM DOES NOT GUARANTEE ELIGIBILITY. PLEASE CHECK ELIGIBILITY PRIOR TO PROVIDING SERVICE.

Authorization #: _____ Date: _____/_____/_____

Provider Contracted Yes ☐ No ☐ Assigned Length of Stay: _____

Facility Contracted Yes ☐ No ☐

_____ Authorized Date _____ Initials _____ CPT Codes Authorized/No. of Visits _____

_____ Pended Date _____ Initials _____ Reason _____

_____ Denied Date _____ Initials _____ Reason _____

_____ Modified Date _____ Initials _____ Reason _____

SE 7-26-00