☐ STAT REQUEST
☐ ROUTINE REQUEST
☐ URGENT REQUEST

My Family Medical Group Authorization Request Form

☐ HMO
☐ NON-HMO
☐ Commercial
☐ Senior

Patient: _____ Patient# _____

Date Requested _____ DOB _____ Phone _____

Date to Committee _____ Date Provider Notified _____ Date Patient Notified _____

Ht _____ Wt _____

Type of Service Requested

☐ *IN-House* ☐ *Specialty Referral* ☐ *2nd Opinion* ☐ *U.R.*

Referring Provider _____ Referred to _____

Findings/Diagnosis _____ Appointment Date/Time _____

Summary of Findings from Referral Physician _____

_____

_____

☐ *Emergency Room* ☐ *Ancillary* ☐ *Hospitalization/Surgery*

Procedure _____

Hospital _____ Estimated LOS _____

Primary Care Physician _____ Admitting MD _____

Pre-Op Physician _____ Date _____ Time _____

Assisting MD _____ Admit Date _____ Procedure Date _____

Diagnosis _____

☐ *DME/Home Health* _____

Company _____ Contact _____

Duration of Order _____ Diagnosis _____

Medical Records Check List

Information to accompany this request (check all that apply):

		Dates			Dates
☐	1. Clinic/Consultation Notes	_____	☐	4. Outside Medical Records	_____
☐	2. OP Report	_____	☐	5. X-RAY Reports/Images	_____
☐	3. Emergency Room Report	_____	☐	6. Lab/Pathology	_____

Type of Insurance _____ ID# _____ Effective Date _____

Eligibility Checked _____ Date _____ ☐ Website ☐ Phone _____

Comments _____

_____

FOR UR USE ONLY

UR Committee Action: ☐ Approved ☐ Non-Covered Benefit ☐ Pt. Not Eligible ☐ Additional Information Needed
☐ Denied ☐ Not Medically Necessary ☐ Alternate Care ☐ M&R Criteria ☐ HR Guidelines

_____ _____ _____

Authorizing UR Representative's Signature Date UR#

Physician Reviewer Available for Discussion of Case (909) 591-6446