Scripps Health Plan

DATE OF REQUEST: ____________

EMERGENT ( ) 858-964-3104
ROUTINE ( ) 858-260-5877
RETRO ( )

SCRIPPS HEALTH PLAN AUTHORIZATION REQUEST FORM

Patient Identification:

Name: ______________________________ MRN: __________ DOB: ___________

Health Plan: __________________________ PCP: ___________________________

Requesting MD:______________________________ Contact Name: ____________________
(At requesting office)

Requestor's Phone #: ( ) _____________

Fax #: ( ) _____________

FAX TO: (858) 260-5877

Service Request:

Check One

( ) Consult / Office visit / MD
( ) Diagnostic test
( ) DME, Orthotic / Prosthetic
( ) **Home Health****
( ) Outpatient Surgery
( ) Inpatient Admission
( ) **PT, OT, Speech Therapy****
( ) Other (specify)

**** ____# VISITS REQUESTED**

Provider Name: __________________________ Facility:_______________________

Diagnosis: 1) __________________________________ ICD-10 Code _____________
2) __________________________________ ICD-10 Code _____________

Description 1) __________________________________ CPT Code _____________
2) __________________________________ CPT Code _____________

Clinical Summary / Reason for Request:

____

____

____

____

Fax to: Scripps Health Plan (858) 260-5877
For Information: Contact Customer Service (844) 337-3700