REQUEST FOR AUTHORIZATION

Office: 209.724.6000 Fax: 209.359.2024

CENTRAL VALLEY PACE

☐ ROUTINE ☐ URGENT

To expedite a determination on your request for service, attach supporting clinical documentation/Medical records
**DME, Home Health, Therapies and Medication must include RX attached

Patient Name:	DOB:
Address:	Phone Number:
Date:	Member ID:

Requesting Physician:	TAX ID:
Address:	NPI:
Phone Number:	FAX Number:

Rendering Facility:	TAX ID:
Address:	NPI:
Phone Number:	FAX Number:

PROCEDURE DESCRIPTION	CPT CODE	QTY	DOS

DIAGNOSIS	ICD 10

Point of Contact: _____

Phone: _____

FAX: _____