NEMS NORTH EAST MEDICAL SERVICES

東 北 醫 療 中 心

Management Services Organization (MSO)
1710 Gilbreth Road
Burlingame, CA 94010
Phone (415) 352-5186 Fax (415) 398-2895

TREATMENT AUTHORIZATION FORM

Type of Request:
☐ Routine ☐ Urgent ☐ Retro

Member Information	Name:_____ Date of Birth:_____ Member ID #:_____
Requesting Provider	Name:_____ Phone #:_____ Fax #:_____
Rendering Provider	Provider Name:_____ NPI:_____ Specialty:_____ Facility:_____ Contact Person:_____ Phone #:_____ Address:_____ Fax #:_____

Diagnosis Description 1:_____ **ICD-10:** _____
Diagnosis Description 2:_____ **ICD-10:** _____
Diagnosis Description 3:_____ **ICD-10:** _____
Diagnosis Description 4:_____ **ICD-10:** _____

Type of Service: ☐ Inpatient ☐ Outpatient ■ Office ☐ DME ☐ Home ☐ Other: _____

Date of Service: _____

For Completion by Referring Provider

Specific Services Requested	Procedure Code (CPT code)	Units of Service	Specific Services Requested	Procedure Code (CPT code)	Units of Service
1.			4.		
2.			5.		
3.			6.		

Medical Justification: *(copy of related medical records/x-ray/lab reports - attach as necessary)*

I certify that the above requests are medically necessary in the care of this patient.

Referring Provider Signature:_____ **Date:**_____

Important Note: *Payment is contingent upon eligibility at the time of service. Providers are responsible for checking patient eligibility prior to rendering services by verifying eligibility directly with member's health plan. Payment to non-contracted/out-of-network providers is based on the current CMS Medicare or DHCS Medi-Cal fee schedule according to member's eligibility at the time of service.*

For NEMS-MSO Use Only

☐ **Approved** ☐ **Modified** ☐ **Denied** ☐ **Deferred**

Comments:_____

By:_____ Date: _____ Date faxed: _____