

# PRIOR AUTHORIZATION FORM

PHOENIX PHYSICIANS IPA, PLLC .  
C/o MSO, Inc. of Southern California  
2670 N. Main St., Suite 100A  
Santa Ana, CA 92705  
Telephone No: (626) 656 - 2370 Ext 122 & 128 and 120  
Specialists : Please Fax Request To (866) 458 - 7482 or (562) 394 - 0641

(Sections A - C must be filled out completely. Failure to complete these sections will delay the approval process.)

## SECTION A PATIENT INFORMATION

Health Plan: Verda Health Plan Product / Service Line: Medicare Advantage  
MEMBER NAME: \_\_\_\_\_ REFERRAL DATE: \_\_\_\_\_ 2026  
DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ GENDER:  F  M

## SECTION B PROVIDER INFORMATION

Please indicate whether the referral is to a participating or non-participating provider:

\*(NOTE: Approval must be obtained before appointment is scheduled.)  Participating Provider  Non-Participating

REFERRED TO (PHYSICIAN/PROVIDER/FACILITY): \_\_\_\_\_ REFERRING PHYSICIAN (PCP/PROVIDER): \_\_\_\_\_  
NAME: \_\_\_\_\_ PCP NAME: \_\_\_\_\_  Referred for Case Mgmt  
SPECIALTY: \_\_\_\_\_ CHIP  Yes  No  
ADDRESS: \_\_\_\_\_ ADDRESS: \_\_\_\_\_  
PHONE NO: (\_\_\_\_) \_\_\_\_\_ PHONE NO: \_\_\_\_\_  
FAX NO: (\_\_\_\_) \_\_\_\_\_ FAX NO: \_\_\_\_\_

## SECTION C REASON(S) FOR REFERRAL

Please select the appropriate referral type:  Urgent (72 hours)  Routine (7 Business days Medicare/5 Business days)  Retro (30 days)

ICD10 CODE : \_\_\_\_\_ ICD10 CODE : \_\_\_\_\_ ICD10 CODE : \_\_\_\_\_ ICD10 CODE : \_\_\_\_\_  
CPT CODE 1 : \_\_\_\_\_ CPT CODE 2: \_\_\_\_\_ CPT CODE 3 : \_\_\_\_\_ CPT CODE 4: \_\_\_\_\_  
QTY\* : \_\_\_\_\_ QTY\* : \_\_\_\_\_ QTY\* : \_\_\_\_\_ QTY\* : \_\_\_\_\_

Accident:  Yes  No DX/Significant Reason(s) for Referral (Attach H&Ps, Progress Notes): \_\_\_\_\_

PCP/SPC SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

\*QUANTITY IS LIMITED TO MAX 5 REQUESTS OR SUFFICIENT FOR 90 DAYS OF TREATMENT PER CPT\*

## ATTENTION: PRIMARY CARE PHYSICIAN REFERRAL REVIEW and PROCESSING

**Primary Care:** Once you have received *or initiated* this authorization request and have reviewed attached supporting documentation, please indicate the following:

### DOCUMENTATION REVIEW:

There is pertinent and timely documentation attached  There **IS NOT** pertinent and timely documentation attached

### PCP REVIEW:

I have reviewed this request and I recommend approval  I have reviewed this request, and I **DO NOT** recommend approval  
 I would like to ask for a second opinion  As the PCP, I would like to reexamine this member to make further determination regarding this request.

Please state your rationale for **NOT APPROVING** of this request:

After completion of your valued opinion, please proceed with filling out referral through PORTERO or by faxing request and all attached documentation to (562)394-0641 for processing and Medical Review.

## IMPORTANT INSTRUCTIONS: TO CONSULTING PROVIDERS AND PCPS. PLEASE READ CAREFULLY.

- Physician Reviewer is available to discuss the outcome of this authorization at (626) 656-2370 X122, 128 and 120
- **Important Notice:** Authorization Referral Form must include ICD-10 and CPT Codes; it will be returned for incompleteness, delaying the approval process. Documentation supporting medical necessity must accompany referral. If medical necessity cannot be established, referral may be denied.
- **SPECIALIST:** If further diagnosis, therapeutic services or consults are indicated, contact the PCP for additional referral information and/or modification to services requested.
- This is not an authorization to admit the member to any inpatient facility. Please contact the PCP if hospitalization is needed. In the event eligibility has been terminated, this referral is no longer valid. **PROVIDERS SHOULD ALWAYS VERIFY ELIGIBILITY PRIOR TO RENDERING SERVICE(S) BY CALLING THE MEMBER'S HEALTH PLAN OR CHECKING ON VERDA PROVIDER PORTAL.**
- To ensure prompt and accurate payment of your fees, attach one copy of this Authorization Referral Form and Progress Notes to your standard bill and send to the above address. **Do Not Bill The Patient/Member.**
- Your claim form must include the CPT Code with corresponding charges, DOS, and ICD-10 Diagnosis Code. **Incomplete Claims Will Be Deferred.**
- Services will be reimbursed according to the Provider Agreement, the patient's type of insurance coverage and/or UC&R. Rev 3.2026

