

**Physicians Medical Group of San Jose, Inc.**

**EXCEL MSO, LLC.**

75 E. Santa Clara Street, Suite 950 San Jose, CA 95113-1848  
Phone: (408) 937-3645 Fax: (408) 937-3637 or (408) 937-3638

**Authorization Request Form**

**Routine Non-Urgent**

**Urgent:** Urgently needed care means services that are required in order to prevent serious deterioration of a member's health that results from an unforeseen illness or injury.

**Retrospective**

**Emergency:** A medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson would expect the absence of immediate medical attention to result in jeopardizing health, serious impairment of body function or dysfunction of any bodily organ or part. (NO AUTHORIZATION IS REQUIRED)

**Health Plan (Please Check)**

<input type="checkbox"/>	Aetna	<input type="checkbox"/>	Blue Shield Commercial	<input type="checkbox"/>	Health Net Medicare Advantage
<input type="checkbox"/>	Alignment	<input type="checkbox"/>	Care1st	<input type="checkbox"/>	SCAN
<input type="checkbox"/>	Anthem Commercial	<input type="checkbox"/>	Cigna	<input type="checkbox"/>	SCFHP Medi-Cal/HK
<input type="checkbox"/>	Anthem Medi-Cal	<input type="checkbox"/>	Health Net Commercial	<input type="checkbox"/>	United Health Plan

**Patient Information**

Date of Request: \_\_\_\_\_

Patient Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

PCP: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Referring Provider: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Person submitting request: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Requested Provider Information**

Requested Provider: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD-10: \_\_\_\_\_

**Requested Service:**

Office Visit/Consultation     Follow-up    # of visits Requested: \_\_\_\_\_

Procedure(s) /CPT: \_\_\_\_\_

Facility: \_\_\_\_\_  Inpatient     Outpatient

OB Care: LMP if known: \_\_\_\_\_ EDC: \_\_\_\_\_ Facility: \_\_\_\_\_

**Clinical Findings and Duration of Treatment Previously Provided (Attach Clinical Notes)**

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