Physicians Medical Group of San Jose, Inc.
EXCEL MSO, LLC.
75 E. Santa Clara Street, Suite 950 San Jose, CA 95113-1848
Phone: (408) 937-3600 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.

Health Plan (Please Check)

☐	Aetna	☐	Blue Shield Medicare Advantage	☐	Health Net Commercial	☐	United Healthcare
☐	Anthem Commercial	☐	Care1st	☐	Health Net Medicare Advantage	☐	
☐	Anthem Medi-Cal/HK	☐	Cigna	☐	Humana	☐	
☐	Blue Shield Commercial	☐	Citizens Choice	☐	SCFHP Medi-Cal/HK	☐	

Patient Information

Date of Request: _____

Patient Name: _____ ID#: _____ Date of Birth: _____

Patient Address: _____ Phone #: _____

PCP: _____ Phone: _____ Fax: _____

Referring Provider: _____ Phone: _____ Fax: _____

Requested Provider Information

Requested Provider: _____ Phone: _____ Fax: _____

Diagnosis: _____ ICD-9: _____ CPT: _____

Requested Service:

☐ Office Visit/Consultation ☐ Follow-up # of visits Requested: _____

☐ OB Care: LMP if known: _____ EDC: _____ Facility: _____

Procedure(s) /CPT: _____ Facility: _____ ☐ Inpatient ☐ Outpatient

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

Signature of Requesting Provider: _____

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Reviewer Notes and findings: (Include clinical criteria used to make the determination)

☐ Approved ☐ Pending ☐ Denied Referral Number_____

Medical Review by: _____ Date:_____

The PMGSJ Medical Director is available to discuss the case Monday – Friday, 8AM to 4:30 PM. Please call (408) 937-3600