# DESIGN BENEFITS ADMINISTRATORS

**Immediate and serious condition with potential to become an emergency** ☐ **STAT**
**Requires immediate action, although not life threatening** ☐ **URGENT**
**Diagnostic studies, elective surgeries, consults, and follow-up** ☐ **ROUTINE**

AUTH/TRACKING NUMBER_____
AUTHORIZATION VALID 90 DAYS FROM DATE OF APPROVAL

| | | | | |
|---|---|---|---|---|
| PATIENT NAME | | PATIENT/MEMBER ID NO/ SS# | | INSURANCE |
| ADDRESS | CITY | ZIP | SEX M ___ F___ | DOB |
| PHONE | | MOTHER' S FULL NAME (if member is under 21) | | |

| | |
|---|---|
| PCP NAME:<br><br>NAME OF REQUESTING PROVIDER: | REFERRAL TO: |
| CONTACT PERSON @ OFFICE | ADDRESS |
| PHONE FAX | PHONE FAX |
| M.D. SIGNATURE | DATE SIGNED/DATE REQUESTED |

**ATTACH ANY CONSULTATION REPORTS, X-RAY REPORTS OR ANY PERTINENT DOCUMENTATION TO SUPPORT MEDICAL NECESSITY**

| | |
|---|---|
| NUMBER OF VISITS REQUESTED: | APPT DATES IF KNOWN: |
| NAME OF SURGICAL FACILITY: | DATE OF SURGERY: |
| DIAGNOSIS: | ICD-9 CODE: |
| PROCEDURE REQUESTED: | CPT CODE: |
| AGE, SEX, HISTORY, PHYSICAL EXAM, DIAGNOSIS, PERTINENT WORK-UP TO DATE, i.e. DIAGNOSTIC STUDIES: | |
| TREATMENT PLAN: | |

**COMPLETED BY Design Benefits Administrators**

| | |
|---|---|
| DATE & TIME APPROVED _____ DATE & TIME PENDED _____ | INITIAL NOTIFICATION TO PCP DATE/TIME _____ |
| DATE & TIME REVIEWED BY UMC _____ DATE &TIME DENIED_____ | WRITTEN NOTICE TO PCP DATE/TIME _____ |
| | WRITTEN NOTICE TO MEMBER DATE/TIME _____ |
| **MEDICAL REVIEWER:** | **DATE RETURNED:** |

**UPON ACCEPTANCE OF REFERRAL AND TREATMENT OF THE PATIENT, PHYSICIAN/PROVIDER AGREES TO ACCEPT IPA CONTRACTED RATES. This Referral/Authorization verifies medical necessity only. Payments for services are dependent upon the patient's eligibility at the time services are rendered.**

Fax completed referral forms to: Fax **760-400-4020**
Authorizations Department Telephone: **760-269-3443**

**PHYSICIAN REVIEWER AVAILABLE TO DISCUSS DECISION AND CRITERIA USED FOR DECISION @ 760-269-3443**