



Utilization Management Dept. (UMD)
 Phone: (714) 634-5169
 Faxes: (714) 634-9655 (714) 978-2367



Medical Services Initiative Referral Request

Patient Information

Last Name _____ First Name _____ Middle Initial _____
 Member ID # _____ Date of Birth _____ Age _____ Male _____ Female _____
 Phone _____ Address _____

Medical Information

Services requested: (consultation, Rx, etc.) _____
 _____ CPT Code(s) _____
 Diagnosis: _____ ICD 9 Code(s) _____
 Symptoms _____

The following must support your request: Past clinical history, findings, evaluation, lab, radiology & consultation reports.

Requesting Physician Name _____ Phone _____
 Contact Name _____ Fax _____

FOR COUNTY MSI USE ONLY

Referral Status: *Note: Response will be received within 5 business days for non urgent referrals.*

Date Request Received by UMD _____
 Approved as Requested _____ Approved/Modified _____
 Tracking Number _____ (Note: Tracking number does not guarantee payment.) Date _____
 Request Denied _____ Reason _____

 Specialists Name _____ Phone _____ Fax _____

DENIAL APPEAL/SECOND LEVEL REVIEW

Appeal Approved as Requested _____ Appeal Approved as Modified _____
 Appeal Denied _____