



AUTHORIZATION SERVICE REQUEST

Expedited Requests: CALL (855) 330-3412 | Standard Requests: FAX 818-688-3957

AUTHORIZATIONS SHOULD BE FAXED OR EMAILED TO UM@brandmanhealthplan.com

Referral Contact: _____ Referral Phone: _____ Date of referral: __/__/__

Member Information		PCP Information	
Name:		Name:	
DOB:		Phone:	
Sex:	<input type="radio"/> F <input type="radio"/> M	Fax:	
Patient ID #:		Signature:	
Phone #:			

Specialist/Serviceing Provider Information

Name:	
Specialty:	
Phone:	
Fax:	
Address:	

Requesting Provider Dx:

Referral Reason:

Primary Procedure / CPT Code:

Direct Referral Request

Secondary Procedure Code (if applicable):

ICD-10 Code:

Specialist can fax completed request form and all applicable documents to
818-688-3957.

This approval is only valid during the duration of the above referenced member's eligibility with Brandman Health Plan