ESTABLISHED CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request	2. Provider name	3. Provider number

4. Address (number, street) | City | State | ZIP code

5. Contact person	6. Contact telephone number ( )	7. Contact fax number ( )

Client Information

8. Client name—last | First | Middle

9. Gender ☐ Male ☐ Female	10. Date of birth (mm/dd/yyyy)	11. CCS/GHPP case number

12. Client index number (CIN)	13. Client's Medi-Cal number

Diagnosis

14.
Diagnosis (DX)/ICD-9: _____ DX/ICD-9: _____ DX/ICD-9: _____

15. Service Authorization Request for *(Check one)*
☐ a. CCS/GHPP New SAR
☐ b. Authorization extension (If checked, enter authorization number: _____)

Requested Services

16.* CPT-4/ HCPCS Code/NDC	17. Specific Description of Service/Procedure	18. From (mm/dd/yy)	To (mm/dd/yy)	19. Frequency/ Duration	20. Units	21. Quantity (Pharmacy Only)

* A specific procedure code/NDC is required in column 16 if services requested are other than ongoing physician authorizations, hospital days, or special care center authorizations.

22. Other documentation attached ☐ Yes	23. Enter facility name (where requested services will be performed, if other than office.

Inpatient Hospital Services

24. Begin date	25. End date	26. Number of days	27. Extension begin date	28. Extension end date	29. Number of extension days

Additional Services Requested from Other Health Care Providers

30. Provider's name | Provider number | Telephone number ( ) | Contact person

Address (number, street) | City | State | ZIP code

Description of services | Procedure code | Units | Quantity

Additional information

31. Provider's name | Provider number | Telephone number ( ) | Contact person

Address (number, street) | City | State | ZIP code

Description of services | Procedure code | Units | Quantity

Additional information

32. Signature of physician/provider or authorized designee	33. Date

INSTRUCTIONS

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Provider number: Enter billing number (no group numbers).
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.

Client Information

8. Client name: Enter the client's name—last, first, and middle.
9. Gender: Check the appropriate box.
10. Date of birth: Enter the client's date of birth.
11. CCS/GHPP case number: Enter the client's CCS/GHPP number. If not known, leave blank.
12. Client index number (CIN): Enter the client's CIN number. If not known, leave blank.
13. Client's Medi-Cal number: Enter the client's Medi-Cal number. If number is not known, leave blank.

Diagnosis

14. Diagnosis and/or ICD-9: Enter the diagnosis or ICD-9 code, if known, relating to the requested services.

Requested Services

15. a. CCS/GHPP New SAR: Check if requesting a new authorization for an established CCS/GHPP client.
    b. Authorization extension: Check if requesting an extension of an authorized request. Please enter the authorization number on the line.
16. CPT-4/HCPCS code/NDC: Enter the requested CPT-4, HCPCS code, or NDC code. This is only required if services requested are other than ongoing physician authorizations or special care center authorizations. Also not required for inpatient hospital stay requests.
17. Specific description of procedure/service: Enter the specific description of the procedure/service being requested.
18. From and to dates: Enter the date you would like the services to begin. Enter the date you would like the services to end. These dates are not necessarily the dates that will be authorized.
19. Frequency/duration: Enter the frequency or duration of the procedures/services being requested.
20. Units: For NDC, enter the total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
21. Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
22. Other documentation attached: Check this box if attaching additional documentation.
23. Enter facility name: Complete this field with the name of the facility where you would like to perform the surgery you are requesting.

Inpatient Hospital Services

24. Begin date: Enter the date the requested inpatient stay will begin.
25. End date: Enter the date the requested inpatient stay will end.
26. Number of days: Enter the number of days for the requested inpatient stay.
27. Extension begin date: Enter the date the requested extension of authorized inpatient stay will begin.
28. Extension end date: Enter the date the requested extended stay will end.
29. Number of extension days: Enter number of days for the requested extension inpatient stay.

Additional Services Requested from Other Health Care Providers

30. and 31. Provider's name: Enter name of the provider you are referring services to.
    Provider number: Enter the provider's provider number.
    Telephone: Enter provider's telephone number.
    Contact person: Enter the name of the person who can be contacted regarding the request.
    Address: Enter address of the provider.
    Description of services: Enter description of referred services.
    Procedure code: Enter the procedure code for requested service other than ongoing physician services.
    Units: For NDC, enter the total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
    Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
    Additional information: Include any written instructions/details here.

Signature

32. Signature of physician or provider: Form must be signed by the physician, pharmacist, or authorized representative.
33. Date: Enter the date the request is signed.