Prior Authorization for Psychiatric Referral

County of Orange CARE Network

1725 W. 17th St. P.O. Box 6099 Santa Ana, CA 92706
Referral Coordinator Marlene Torres (714) 834–8026, Fax (714) 834–8418
Christopher Ried, MD, Medical Director (714) 834-7991, Voicemail (714) 834-8598

PATIENT INFORMATION

Patient Name: _____ (Last) _____ (First)

Date of Birth: _____ (mm/dd/yy) Gender: ☐ Male ☐ Female ☐ Transgender M to F ☐ Transgender F to M

Address: _____ (Street) _____ (City) _____ (Zip)

Home Phone: _____ (Including Area Code) Alternate Phone: _____ (Including Area Code)

REFERRING PROVIDER INFORMATION

Name: _____ Title: _____

Agency Name: _____ Date of Referral: _____

Address: _____ (Street) _____ (City) _____ (Zip)

Phone: _____ (Including Area Code) Fax: _____ (Including Area Code)

ALL CRITERIA MUST BE MET IN ORDER FOR THE REFERRAL TO BE ACCEPTED:

☐ Signed authorization by provider or case manager to disclose patient protected health information (PHI) to Orange County Health Care Agency 17th Street Care Clinic is attached.

☐ I, as the person making this referral, have ensured that eligibility and financial assessment have been conducted and all required documents are present and filed in the eligibility section of the client file. Clients shall be informed of their right to: confidentiality in accordance with state and federal laws, informed consent, explanation of grievance procedures and Client Rights and Responsibilities.

☐ I, as the person making this referral, have ensured that Ryan White funds are the payer of last resort and that this client does not currently have and is not eligible for any of the following:

- Medi-Cal
- CalOptima
- MediCare

☐ I, as the person making this referral, have verified that the clients' private medical insurance does not cover psychiatry services.

Signature: _____ Date: _____

SERVICE REQUEST INFORMATION

Requested Consult: ☐ Routine Consult ☐ Urgent Consult (Must call Dr. Ried)

Diagnosis:

Past Psych History:

Reason for Referral (detail symptoms/severity):

DO NOT WRITE BELOW THIS LINE - FOR HCA USE ONLY

PA Decision Status: ☐ Approved ☐ Modified ☐ Denied/Not a covered service ☐ Denied/Not Medically Indicated ☐ Deferred For More Information ☐ Not Eligible for RW funds

Signature: _____ Date: _____

Initial Consult Appointment

Date: _____ **Time:** _____