CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

REENTRY (REPS) SERVICE REQUEST FORM

Email: CDCRCCHCSREPSMedical@CDCR.ca.gov

☐ MCRP ☐ FCRP ☐ OTHER:		
Service is: ☐ **NON-URGENT** ☐ **URGENT** ABUSE OF URGENT PA STATUS WILL BE MONITORED. Urgent requests MUST be reserved for requests that are potentially life threatening or pose a significant risk to the continuous care of the patient, in the provider's best professional judgment. Services for urgent requests must be provided within 14 days of signing request. CCHCS reserves judgment of urgency and must meet definition above, therefore, please explain reason for urgency below.		Date:
Patient Name: (Last, First, Middle Initial)	Date of Birth:	CDCR #:

Referral/Service Type Requested

☐ Specialist Consult/Tx/FU Care	☐ LOC Change	☐ Surgical Procedure
☐ Inpatient Admission	From_____ To_____	☐ Inpatient ☐ Outpatient
☐ Major Diagnostic Procedure	☐ Mental Health	Facility:
☐ Medication (non-formulary)	☐ Other:	Date of Service:
☐ DME (refer to PA list)	☐ Comments:	

Requesting Provider Information	Referring To Provider Information
Requesting Provider Name: (Last, First)	Referring To Provider Name: (Physician, mg.ipa, Facility, Agency)
Address: (No., Street, City, State, Zip)	Address: (No., Street, City, State, Zip)
Specialty:	Specialty:
Phone Number:	Phone Number:
Fax Number:	Fax Number:

Service Request Information

ICD-10 Code #/Description:	Code or Description:

Clinical Indications for Request: (Include pertinent past medical history, treatment, physical findings, and attach all relevant medical records and test results, etc.)

Requesting Practitioner Signature:	Date:

CCHCS UM Staff Use Only

Criteria/Guidelines Met: ☐ Yes ☐ No	Authorization Status: ☐ Approved	☐ Deferred	☐ Denied
Comments:			
UM Representative Signature:		Date:	

UM Review

☐ APPROVED	COMMENTS:
☐ MODIFIED	
☐ DENIED	
UM Physician's Signature:	Date:

CLAIMS PAYMENT IS CONTINGENT UPON PRIOR AUTHORIZATION OF SERVICE