

REENTRY (REPS) SERVICE REQUEST FORM

Email: CDCRCCHCSREPSMedical@CDCR.ca.gov

<input type="checkbox"/> MCRP <input type="checkbox"/> FCRP <input type="checkbox"/> OTHER:		
Service is: <input type="checkbox"/> NON-URGENT <input type="checkbox"/> 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:
Referral/Service Type Requested		
<input type="checkbox"/> Specialist Consult/Tx/FU Care	<input type="checkbox"/> LOC Change From _____ To _____	<input type="checkbox"/> Surgical Procedure <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient
<input type="checkbox"/> Inpatient Admission	<input type="checkbox"/> Major Diagnostic Procedure	Facility:
<input type="checkbox"/> Medication (non-formulary)	<input type="checkbox"/> Mental Health	Date of Service:
<input type="checkbox"/> DME (refer to PA list)	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Authorization Status: <input type="checkbox"/> Approved <input type="checkbox"/> Deferred <input type="checkbox"/> Denied	
Comments:		
UM Representative Signature:		Date:
UM Review		
<input type="checkbox"/> APPROVED	COMMENTS:	
<input type="checkbox"/> MODIFIED		
<input type="checkbox"/> DENIED		
UM Physician's Signature:		Date:

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CLAIMS PAYMENT IS CONTINGENT UPON PRIOR AUTHORIZATION OF SERVICE