P.O. Box 8350
La Verne, CA 91750

Phone: (888) 293-6383
Fax: (888) 320-3851

Request Date: _____

MODIFICATION REQUEST FORM (MRF)

***** IN ORDER TO PROCESS YOUR REQUEST, MRF MUST BE COMPLETED AND LEGIBLE. MRFs MUST BE SENT VIA FAX*****

PROVIDER: Modifications may not be accepted if decision has already been made or authorization is beyond regulatory turn-around time. For routine requests this is 5 days for Medicaid and 14 days for Medicare Authorization does not guarantee payment, ELIGIBILITY must be verified at the time services are rendered. Modifications of a referral can be made to update the following: ICD or CPT codes, Number of Units, and Provider/Facility name.

Authorization Request #: _____ **Original Authorization Date:** _____

Patient Name: _____ **M** ☐ **F** ☐ **D.O.B.** _____ **Age:** _____
Last First

Member ID : _____ **Name of Facility (if applicable:** _____

Requesting Provider:	**Servicing/Requested Provider (Physician, Facility, Vendor):**
Provider NPI# _____ **Provider TIN#:** _____	**Provider NPI#:** _____ **Provider TIN#:** _____
Address: _____ **Phone:** _____ _____ **Fax:** _____	**Address:** _____ **Phone:** _____ _____ **Fax:** _____
Office Contact: _____	**Office Contact:** _____
Diagnosis: _____	**ICD-10:** _____

Originally Requested Authorizations

☐ **Inpatient Facility** ☐ **Surgery Center/OP** ☐ **SNF** ☐ **Medical Services/Items** ☐ **Part B Drugs**

Date(s) of Service: _____ **Inpatient Admission Date:** _____

List ALL procedures requested along with the appropriate CPT/HCPCS

REQUESTED PROCEDURES	PERTINENT HISTORY (Submit supporting Medical Records)	CODE (CPT or HCPCS)	UNITS (REQUIRED)

Requested Modifications

☐ **Inpatient Facility** ☐ **Surgery Center/OP** ☐ **SNF** ☐ **Medical Services/Items** ☐ **Part B Drugs**

Date(s) of Service: _____ **Inpatient Admission Date:** _____

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