



**KEY MEDICAL GROUP, INC.**

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**KEY MEDICAL USE ONLY**

Date Request Received \_\_\_\_\_

Date Pended/Deferred \_\_\_\_\_

Date Additional Info Received \_\_\_\_\_

Date of Decision \_\_\_\_\_

**Referral Authorization Form**

(To ensure your request is returned please provide the fax number)

\_\_\_\_\_  
Requesting Physician / Provider

\_\_\_\_\_  
Primary Care Physician

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Fax Number

Blue Shield

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Policy or Group # \_\_\_\_\_ Member ID # \_\_\_\_\_

Procedure/Consultation Requested	CPT Code(s)	ICD-9 code(s)

**Medical History (include therapies tried & investigational tests performed):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Referred to: Name/Specialty:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Place of Service:** \_\_\_\_\_

IN PATIENT

OUT PATIENT

**APPOINTMENTS SHOULD NOT BE MADE WITHOUT PRIOR AUTHORIZATION GIVEN**

**M.D. Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Authorization Number:** \_\_\_\_\_ **Valid Until:** \_\_\_\_\_

**Modifications:** \_\_\_\_\_

**Authorized Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**AUTHORIZATION DOES NOT GUARANTEE PAYMENT FOR SERVICES**  
**ALL PAYMENTS ARE SUBJECT TO HEALTH PLAN PROVISIONS**