



# COVERAGE DETERMINATION FORM (CDF)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

360 Campus Lane, Suite 100

Fairfield, CA 94534

(707) 863-4414 or (800) 863-4155

## PartnershipAdvantage (HMO)

### (707) 419-7900 FAX

A Partnership HealthPlan of California Medicare Plan

(FOR PROVIDER USE)

REQUEST IS RETROACTIVE?

YES  NO

PROVIDER PHONE NO.

( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )

PATIENTS AUTHORIZED REPRESENTATIVE (IF ANY)  
ENTER NAME AND ADDRESS:

PLEASE TYPE YOUR NAME AND ADDRESS HERE

PROVIDER NAME AND ADDRESS

•

•

•

•

•

MEDICARE PROVIDER NO.

\_\_\_\_\_

\_\_\_\_\_

FOR PHC USE ONLY

PROVIDER: YOUR REQUEST IS:

APPROVED AS REQUESTED  DENIED  DEFERRED

APPROVED AS MODIFIED

BY: \_\_\_\_\_  
PHC CONSULTANT'S NAME

DATE

\_\_\_\_\_

REVIEW COMMENT INDICATOR

COMMENTS / EXPLANATION

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

NAME AND ADDRESS OF PATIENT  
PATIENT NAME (LAST, FIRST, M.I.)

IDENTIFICATION NO.

\_\_\_\_\_

STREET ADDRESS

\_\_\_\_\_

SEX  AGE  DATE OF BIRTH

\_\_\_\_\_

CITY, STATE, ZIP CODE

\_\_\_\_\_

HOME  ACUTE HOSPITAL

PHONE NUMBER  
AREA ( )

DIAGNOSIS DESCRIPTION: \_\_\_\_\_ CURRENT ICD-9CM CODE \_\_\_\_\_

MEDICAL JUSTIFICATION:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

LINE NO.	AUTHORIZED		APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC / UPC OR PROCEDURE CODE	QUANTITY	CHARGES
	YES	NO						
1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			
2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			
3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			
4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			
5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			
6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>			

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

FROM DATE  TO DATE

TAR CONTROL NUMBER

SEQUENCE NUMBER

PI

SIGNATURE OF PHYSICIAN OR PROVIDER

TITLE

DATE

OFFICE

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.