



Phone: (714) 246-8446
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AUTHORIZATION REQUEST FORM (ARF) For CalOptima Kids Weight Management Program Services

PATIENT/PROVIDER INFORMATION

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

Mailing Address: _____ City: _____ Zip: _____

Client Index # (CIN): _____ Phone: _____ Cell Phone: _____

Referring Provider:	Health Network:
Provider Address:	Provider Phone:
City: _____ State: _____ Zip Code: _____	Provider Fax:
Office Contact Name/Phone #:	Physician's Signature:
Diagnosis: (1) _____ (2) _____	ICD.9 (1) _____ ICD.9 (2) _____

AUTHORIZATION REQUEST

CRITERIA:

- Enrollment in the CalOptima Kids - Healthy Families Program (ELIGIBILITY must be verified at the time services are rendered).
- Meets ≥ 95 Percentile Body Mass Index (BMI) BMI = (Weight in lbs/Height in inches)/Height in inches x 703]
 Height: _____ Weight: _____ Body Mass Index Score: _____
- Child is 4 - 18 years old
- No Co-morbidities (Some exceptions will be made for children with uncomplicated co-morbidities. These will be evaluated on a case by case basis. Please list possible uncomplicated co-morbidities below).
- Lab results attached (The following labs must be included in order to process ARF: CBC, Cholesterol Panel HDL, LDL, T3,T4, TSH, Liver Function Tests, C-Peptide, Fasting Blood Glucose and Urinalysis)

HISTORY AND RELEVANT LAB VALUES:

DO NOT WRITE BELOW THIS LINE

FOR CalOptima Kids USE ONLY

STATUS	Authorization Number #
<input type="checkbox"/> Approved	Signature: _____ Date: _____
<input type="checkbox"/> Community Based Health Education Program <input type="checkbox"/> Medical Based Intervention Program	Comments:
<input type="checkbox"/> Not Approved	Phone Number: