# CCS/GHPP DISCHARGE PLANNING SERVICE AUTHORIZATION REQUEST (SAR)

## Hospital Information

| 1. Date of request | 2. Hospital name | 3. Provider number |
|---|---|---|
| | | |

4. Address (number, street) | City | State | ZIP code

| 5. Contact person/discharge planner | 6. Telephone number ( ) | 7. Fax number ( ) |
|---|---|---|
| | | |

## Client Information

8. Client name—last | first | middle

| 9. Alias (AKA) | 10. Gender ☐ Male ☐ Female | 11. Date of birth (mm/dd/yyyy) |
|---|---|---|
| | | |
| 12. CCS/GHPP case number | 13. Contact phone number ( ) | 14. Medical record number (hospital or office) |
| | | |

15. Residence address (number, street) *(DO NOT USE P.O. BOX)* | City | State | ZIP code

16. Mailing address (if different) (number, street, P.O. box number) | City | State | ZIP code

| 17. County of residence | 18. Language spoken | 19. Name of parent/legal guardian |
|---|---|---|
| | | |
| 20. Mother's first name | 21. Primary care physician (if known) | 22. Primary care physician telephone number ( ) |
| | | |

## Insurance Information

| 23.a. Enrolled in Medi-Cal? ☐ Yes ☐ No | 23.b. If yes, client index number (CIN) | 23.c. Client's Medi-Cal number |
|---|---|---|
| | | |

| 24. Enrolled in Healthy Families? ☐ Yes ☐ No | If yes, name of plan |
|---|---|
| | |

| 25. Enrolled in commercial insurance plan? ☐ Yes ☐ No | If yes, type of commercial insurance plan ☐ PPO ☐ HMO ☐ Other | Name of plan |
|---|---|---|
| | | |

26. Diagnosis

27. Plan to discharge to: ☐ Home ☐ Transfer to (specify):_____

## Specific Discharge Planning Services Requested

**28. Provider's name** | Provider number | Telephone number ( ) | Contact person

Address | City | State | ZIP code

| Description of services | EPSDT SS? ☐ Yes ☐ No | Procedure code | Units | Quantity |
|---|---|---|---|---|
| | | | | |

Additional information | Frequency/duration

**29. Provider's name** | Provider number | Telephone number ( ) | Contact person

Address | City | State | ZIP code

| Description of services | EPSDT SS? ☐ Yes ☐ No | Procedure code | Units | Quantity |
|---|---|---|---|---|
| | | | | |

Additional information | Frequency/duration

| 30. Signature of discharge planner | 31. Title |
|---|---|
| | |

| 32. Name of discharging physician | 33. Date |
|---|---|
| | |

| 34. Client name—last | first | middle |
|---|---|---|

| 35. Date of request | 36. Contact person/discharge planner | 37. Telephone number ( ) |
|---|---|---|

## Specific Discharge Planning Services Requested *(continued)*

| **38. Provider's name** | Provider number | Telephone number ( ) | Contact person |
|---|---|---|---|
| Address | | City | State ZIP code |

| Description of services | EPSDT SS? ☐ Yes ☐ No | Procedure code | Units | Quantity |
|---|---|---|---|---|
| Additional information | Frequency/duration | | | |

| **39. Provider's name** | Provider number | Telephone number ( ) | Contact person |
|---|---|---|---|
| Address | | City | State ZIP code |

| Description of services | EPSDT SS? ☐ Yes ☐ No | Procedure code | Units | Quantity |
|---|---|---|---|---|
| Additional information | Frequency/duration | | | |

| 40. Signature of discharge planner | 41. Title |
|---|---|

| 42. Name of discharging physician | 43. Date |
|---|---|

## INSTRUCTIONS

1. and 35. Date of request: Date the request is being made.

### Hospital Information

2. Hospital name: Enter the legal name of the hospital requesting the services.
3. Provider number: Enter inpatient billing number.
4. Address: Enter the hospital's address.
5. and 36. Contact person: Enter the name of the person who can be contacted regarding the request.
6. and 37. Contact person telephone number: Enter the phone number of the contact person.
7. Fax number: Enter the fax number of the hospital or contact person.

### Client Information

8. and 34. Client name: Enter the client's name, last, first, and middle.
9. Alias (AKA): Enter patient's alias, if known.
10. Gender: Check the appropriate box.
11. Date of birth: Enter the client's date of birth.
12. CCS/GHPP case number: Enter the client's CCS/GHPP number. If number not known, leave blank.
13. Contact phone number: Enter the phone number where the client's parent/legal guardian can be reached.
14. Medical record number: Enter the patient's hospital or office medical number.
15. Residence address: Enter the client's address. Do not use a P.O. Box number.
16. Mailing address: Enter mailing address if different than 15.
17. County of residence: Residential county of the client.
18. Language spoken: Enter the client's language spoken.
19. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
20. Mother's first name: Enter the client's mother's first name.
21. Primary care physician: Enter client's primary care physician's name; if it is not known, enter NK (not known).
22. Primary care physician telephone number: Enter client's primary physician's phone number.

### Insurance Information

23. Enrolled in Medi-Cal? Check the appropriate box. If the answer is yes, enter the client's index number in box 23.b. and the client's Medi-Cal number in box 23.c.
24. Enrolled in Healthy Families? Check the appropriate box. If the answer is yes, enter the name of the plan.
25. Enrolled in a commercial insurance plan? Check the appropriate box. If the answer is yes, check type of commercial insurance plan and enter the name of the insurance plan on the line provided.

### Diagnosis/Discharge Plan

26. Diagnosis: Enter the diagnosis, if known, relating to the requested services.
27. Plan to discharge: Check the appropriate box. If "transfer to" is checked, please specify where on line provided.

### Specific Discharge Planning Services Requested

28., 29., 38., and 39. Provider's name: Enter name of the provider who will be performing the services requested.
Provider number: Enter the provider's provider number.
Telephone number: Enter phone number of the provider.
Contact person: Enter name of contact person at the provider's office.
Address: Enter provider's address.
Description of services: Describe service that is being requested.
EPSDT SS?: Check appropriate box. If yes, contact the State for prior authorization.
Procedure code: Enter the procedure code for the service being requested.
Units: For NDC, enter total number of fills plus refills. For all other codes enter the total number/amount of services/supplies requested for SAR effective dates.
Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
Additional information: Include any written details/instructions here.
Frequency/duration: Enter the frequency or duration of the procedures/services being requested.

### Signature

30. and 40. Signature of discharge planner: Discharge planner signs here.
31. and 41. Title: Enter the title of person signing the document.
32. and 42. Name of discharging physician: Enter the name of the discharging physician.
33. and 43. Date: Enter the date signed.