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. Medical record number (hospital or office)	14. Home phone number ( )
15. Cell phone number ( )	16. Work phone number ( )	17. Email address

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

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

20. County of residence	21. Language spoken	22. Name of parent/legal guardian
23. Mother's first name	24. Primary care physician (if known)	25. Primary care physician telephone number ( )

Insurance Information

26.a. Enrolled in Medi-Cal? ☐ Yes ☐ No	26.b. If yes, client index number (CIN)	26.c. Client's Medi-Cal number

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

28. Diagnosis

29.

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

Specific Discharge Planning Services Requested

30. 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			

31. **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			

32. Signature of discharge planner	33. Title

34. Name of discharging physician	35. Date

36. Client name—last	first	middle

37. Date of request	38. Contact person/discharge planner	39. Telephone number ( )

Specific Discharge Planning Services Requested *(continued)*

40. **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			

41. **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			

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not be processed.

42. Signature of discharge planner	43. Title
44. Name of discharging physician	45. 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 National Provider Identification (NPI) number.
4. Address: Enter the hospital's address.
5. and 38. Contact person: Enter the name of the person who can be contacted regarding the request.
6. and 39. 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 36. 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 California Children's Services (CCS)/Genetically Handicapped Persons (GHPP) number. If number not known, leave blank.
13. Medical record number: Enter the patient's hospital or office medical number.
14. Home phone number: Enter the home phone number where the client's parent/legal guardian can be reached.
15. Cell phone number: Enter the cellular phone number where the client's parent/legal guardian can be reached.
16. Work phone number: Enter the work phone number where the client's parent/legal guardian can be reached.
17. Email address: Enter the email address of the client or client's legal guardian.
18. Residence address: Enter the client's address. Do not use a P.O. Box number.
19. Mailing address: Enter mailing address if different than 18.
20. County of residence: Residential county of the client.
21. Language spoken: Enter the client's language spoken.
22. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
23. Mother's first name: Enter the client's mother's first name.
24. Primary care physician: Enter client's primary care physician's name; if it is not known, enter NK (not known).
25. Primary care physician telephone number: Enter client's primary physician's phone number.

Insurance Information

26. Enrolled in Medi-Cal? Check the appropriate box. If the answer is yes, enter the client's index number in box 26.b. and the client's Medi-Cal number in box 26.c.
27. 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

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

Specific Discharge Planning Services Requested

30., 31., 40., and 41. 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

32. and 42. Signature of discharge planner: Discharge planner signs here.
33. and 43. Title: Enter the title of person signing the document.
34. and 44. Name of discharging physician: Enter the name of the discharging physician.
35. and 45. Date: Enter the date signed.