CalOptima
A Public Agency
Better. Together.

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Long-Term Care Treatment in Place Notification Form

Dates of Service Requested From: _____ To: _____

PROVIDER: Authorization does not guarantee payment.
CalOptima ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ ☐ Male ☐ Female Date of Birth: _____

Mailing Address: _____ City: _____ ZIP: _____

Phone: _____ CIN#: _____

Facility Name: _____

Facility Address: _____ City: _____ ZIP: _____

Phone: _____ Fax: _____ Medi-Cal Provider ID#/NPI: _____

Diagnosis: _____ Physician's Name: _____

Significant Signs and Symptoms of Acute Illness:

☐ _____ ☐ _____ ☐ _____

☐ _____ ☐ _____ ☐ _____

DO NOT WRITE BELOW THIS LINE FOR CalOptima USE ONLY

COMMENTS:

Signature: _____ **Date:** _____