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Family/Seniors Medical Group, Inc.
Menifee Valley Medical Group, Inc.
Hemet Community Medical Group, Inc.
Temecula Valley Physicians Medical Group, Inc.
1545 W. Florida Ave., Hemet, CA 92543

PRIOR AUTHORIZATION
CLINICAL CRITERIA REQUEST FORM

Please complete this form and fax it to PromiseCare to receive a copy of the clinical criteria used to make final clinical decisions for prior authorization. ALL fields must be completed before faxing. Please fax the completed form to 1-888-856-5594.

SECTION I: PATIENT INFORMATION

LAST NAME, FIRST NAME (PLEASE PRINT)	DOB (MM/DD/YYYY)
STREET ADDRESS	PHONE NUMBER
CITY	STATE
CARDHOLDER ID #	ZIP CODE

SECTION II: PHYSICIAN/PROVIDER INFORMATION

PHYSICIAN / PROVIDER NAME	
PHYSICIAN / PROVIDER ADDRESS (STREET, CITY, STATE, ZIP CODE)	
PHYSICIAN / PROVIDER PHONE NUMBER	PHYSICIAN / PROVIDER FAX NUMBER

SECTION III: REQUESTED SERVICE INFORMATION

DESCRIBE SERVICE OR PROCEDURE REQUESTED

DISCLAIMER: Incomplete or illegible forms and missing fields may delay the processing of your request. Please complete all fields to ensure appropriate processing.

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PRIVACY DISCLAIMER: Privacy is important to us. Our employees are trained regarding the appropriate way to handle plan participants private health information.