Substance Use Disorder Services DMC-ODS

Authorization Request Packet-Contracted Provider to El Dorado Co.

Please attach the following and complete the bottom portion of this form in order to initiate DMC-ODS initial or continuing authorization.

Send packet securely to: ODSAccess@edcgov.us

Date of Request: _____

	Verification of El Dorado County Medi-Cal
	Verification of Pregnancy/ Proof of Birth (Perinatal Only)
	Treatment Authorization Request Form
	Current Release of Information
	Narrative basis for diagnosis written by LPHA (initial authorization only)
	Medical Necessity determination completed by LPHA (initial authorization only)
	EDC_ODS_Disclosures_Receipt_Form (initial authorization only)

Beneficiary Name: _____

Beneficiary's most severe impairments

1.
2.
3.

Requesting Staff Name and Signature: _____

Requesting Facility Name and Phone #: _____