

STANDARD REFERRAL FORM

Referral From	Provider Last Name First Name MI	UPIN	Patient's PCP Name (if not referring provider)
Tax ID#	Contact Person's Name	Telephone Number	Fax Number

Patient Information	Last Name	First Name	MI	DOB	MM/DD/YYYY
<input type="radio"/> Male <input type="radio"/> Female	Member ID #	Patient's Contact Phone	Fluent Language if Not English	Interpreter Required?	<input type="radio"/> Yes <input type="radio"/> No
Parent / Legal Guardian Last Name	First Name	MI	Contact Phone		
Subscriber's Last Name	First Name	MI	Subscriber's ID #		
Provider Network	Primary Health Plan	Product Name	Plan's Assigned Number	Secondary Coverage?	<input type="radio"/> Yes <input type="radio"/> No

Referral To	Provider Name	At Clinic/Facility/Name	<input type="radio"/> Please Call Patient to Schedule Appointment
Telephone Number	Specialty	# of Requested Visits	<input type="radio"/> Patient to call
Referral is good for _____ months from referral date	Other Considerations		<input type="radio"/> Appt. Date: _____ Time: _____

Date Referred: _____ ROUTINE URGENT EMERGENCY

Action Requested: Consult Only Evaluate and Treat Assume Management
 Itemized Services Evaluate and Treat - Surgery if Indicated

Restrictions _____

Reason for Referral: _____
 _____ Diag. Group: _____
 _____ ICD9 Code: _____

Instructions, Procedures and ITEMIZED SERVICES: _____

Office Procedure _____ OB Care _____
 DME _____ Home Health _____
 Therapies _____

X _____

Signature	Date
Clinical Findings	Enclosed Available at:
Lab _____	<input type="checkbox"/> _____
X-Ray _____	<input type="checkbox"/> _____
Chart Notes/Letter _____	<input type="checkbox"/> _____
Diagnostic Imaging _____	<input type="checkbox"/> _____
Other (specify) _____	<input type="checkbox"/> _____

Reserved for Provider Office Use

*** NOTE: THIS REFERRAL REQUEST DOES NOT GUARANTEE PAYMENT. SERVICES DOCUMENTED ON THIS REFERRAL FORM MAY REQUIRE PLAN REVIEW. PLEASE CONTACT THE INSURANCE CARRIER TO VERIFY THE PATIENT'S ELIGIBILITY AND BENEFITS. AN INCOMPLETE FORM MAY RESULT IN DELAY OF PROCESSING.**