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	
Male / Female	Member ID # - -	Patient's Contact Phone - -	Fluent Language if Not English — Interpreter Required? Yes / 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?	Yes / No

Referral To	Provider Name At Clinic/Facility/Name		Please Call Patient to Schedule Appointment
Telephone Number - -	Specialty	# of Requested Visits	Patient to call
Referral is good for _____ months from referral date	Other Considerations		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		
X-Ray		
Chart Notes/Letter		
Diagnostic Imaging		
Other (specify)		

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.**