FREEDOM HEALTH

OPTIMUM HealthCare, Inc.

REFERRAL FORM

Fax to: (888) 314-0796

Date:_____ Referral Begin Date:_____ End Date:_____ (Dates left blank will default to 90 days)

Member Information

Name:_____

Date of Birth:_____ ID#:_____

Phone: (_____)_____

Referring Physician Information

Name:_____

Phone: (_____)_____ Fax: (_____)_____

Contact Person:_____ Ext._____

Referred To

(Check one) ☐ Physician ☐ Radiology Center ☐ P&O < $500 ☐ Therapy (Must be a par provider) ☐ DME < $500

Name:_____

Address:_____

_____

Phone: (_____)_____ Fax: (_____)_____

Tax ID#:_____

ICD-10:_____ Description:_____

☐ Office Visit x _____ visit(s) ☐ Office Visit and treatment x ____ visit(s)

☐ Office Visit and Treatment x _____ visits with listed services ☐ PT ☐ OT ☐ ST x ____ visit(s)

Code:_____ Description:_____ Code:_____ Description:_____

Code:_____ Description:_____ Code:_____ Description:_____

Facility

Ambulatory Surgery Center only (Inpatient and Outpatient Hospital require Pre-Certification)

Name of Facility:_____ (Must be par provider)

Address:_____

_____

Phone: (_____)_____ Fax: (_____)_____

Tax ID#: _____

COMMENTS OR ADDITIONAL CODES:

Note to receiving Provider/Facility: This referral form is only for services listed above. If you are a non-participating provider, Inpatient Facility or Outpatient Hospital provider an authorization is required for your services. This is not an authorization form and payment is therefore not guaranteed. If you have any questions please call Utilization Management at (888) 796-0947.

Instructions: (This form is for referral to the following only)

- **Participating specialists** for office visit and treatments in the office that do not require pre-certification.
- **Free-standing** (not hospital-based) radiology centers for CT scans and MRIs.
- **Ambulatory Surgery Centers** - except for excluded procedures (See Pre-Certification List).
- **Orthotics/Prosthetics** - only orthotic/prosthetic with a purchase price less than $500.00.
- **Physical, Occupational or Speech Therapy**: In free-standing office for Evaluation plus 9 visits (10 total) – home therapy or outpatient therapy and visits more than 10 require Pre-Certification.
- **DME -** only DME with a purchase price less than $500.00 or monthly rental price less than $38.50 per month. Excludes: all wheelchairs, hospital beds, CPAPs, BiPAPs, nerve and bone growth stimulation devices and oxygen, as well as TENS devices, wound care/wound vacuums and related supplies, repairs, miscellaneous codes and all Medicare non-covered items.

One copy to patient's chart and one copy to the Provider and one copy faxed to Plan