



REFERRAL FORM

Fax to: (888) 314-0796

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

Member Information	Referring Physician Information
Name: _____	Name: _____
Date of Birth: _____ ID#: _____	Phone: (____) _____ Fax: (____) _____
Phone: (____) _____	Contact Person: _____ Ext. _____

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

Name: _____	Phone: (____) _____ Fax: (____) _____
Address: _____	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: _____
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Code: _____ Description: _____	Code: _____ Description: _____
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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 radiology procedures, except for exclusions (see Pre-Certification List). Simple x-rays, ultrasounds and CT scans can be performed with just a prescription.
- **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