# 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.**

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