

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 ☐ Patient to call ☐ Appt. Date: _____ Time: _____
	Telephone Number	Specialty	# of Requested Visits		
	- -				
Referral is good for _____ months from referral date		Other Considerations			

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 _____

☐ DME _____

☐ Therapies _____

☐ OB Care _____

☐ Home Health _____

X		Reserved for Provider Office Use	
Signature	Date		
Clinical Findings	Enclosed		Available at:
Lab _____	☐		_____
X-Ray _____	☐		_____
Chart Notes/Letter _____	☐		_____
Diagnostic Imaging _____	☐		_____
Other (specify) _____	☐	_____	

*** 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.**