REFERRAL REQUEST FORM

**Fax request to (214) 452-1905 for outpatient. Facility/Inpatient requests fax to (214) 452-1906**

**Date Submitted**

**□ STANDARD**

**□ URGENT**

**Referring Provider Phone # Fax #**

□ OFFICE □ AMBULATORY SURGICAL CENTER □ OUTPATIENT HOSPITAL REQUESTED DATE OF SERVICE

□ HOME □ DME □ INPATIENT/ACUTE □ REHAB/ LTAC □ SNF SCHEDULED ADMIT DATE

Member Name (full name) Date of Birth

Member ID# □ Other Insurance/Worker’s Comp

PCP Name PCP Phone #

***Requested Services***

CPT/HCPCS Code Qty □ units □ visits Procedure description

CPT/HCPCS Code Qty □ units □ visits Procedure description

CPT/HCPCS Code Qty □ units □ visits Procedure description

CPT/HCPCS Code Qty □ units □ visits Procedure description

***Diagnosis***

ICD code Dx description ICD code Dx description

ICD code Dx description ICD code Dx description \_

***Requested Specialist/Provider***

Name Specialty

Phone # Fax #

Tax ID# NPI #

***Requested Facility***

Facility Name Phone #

Tax ID# NPI #

***Please Attach Clinicals/Therapy/Prescription/Imaging to support Medical Necessity***

**Only completed referrals will be processed. Do not combine multiple requests for different specialties in a single fax**

**This referral is valid only for services authorized on this form. *This Referral Form does not guarantee payment by IHHMG or the Health Plan. Responsibility for payment shall be subject to member eligibility, benefit limitations, and the interpretation of benefits under applicable subrogation and coordination of benefits rules. As the Primary Care Physician (PCP), I am referring this patient to you for the above treatment. For any other services it will be necessary to obtain an additional referral authorization.***

***2020 01***