

Direct Access Referral Form EXTX

# Complete all sections of the form and give original tothe member. No additional authorizationis needed. Retaincopy in patient records.

***Member Information***

**Full Name Date of Birth \_ Gender M F**

□

□

**Phone Number Health Plan Member ID# \_**

**PCP Name PCP Phone # \_ PCP Fax # \_**

***Diagnosis***

**ICD code \_ Dx description ICD code Dx description \_**

***Requested Specialist/Provider***

**Name \_ Specialty**

**Address City State \_ Zip Code Phone # \_ Fax #**

|  |  |  |
| --- | --- | --- |
| **QTY** | **OUTPATIENT VISITS** | |
| 1 | 99201 - 99204 | New Patient Consults |
|  | 99211 – 99214 | Established Patient Follow-Up **(Up to 3 Visits)** |
| **QTY** | **PHYSICAL THERAPY** | |
|  | MCR - 9 series MCL - X codes | Physical Therapy Evaluation and 2 treatment visits |
| **QTY** | **X-RAYS** | |
|  | 73560 - 73660 | Lower Leg, Ankle & Foot |
|  | 73090 - 73140 | Forearm & Hand |
|  | 73030 - 73085 | Shoulder & Upper Arm |
|  | 73501 - 73552 | Pelvic Region & Thigh |
|  | 71045 - 71048 | Thorax (Chest) |
|  | 71100 - 71130 | Ribs, Sternum & Sternoclavicular Joint(s) |
|  | 72020, 72040, | Spine (1-3 views) |
| 72070 - 72082 |
| **QTY** | **MAMMOGRAPHY** |  |
|  | 77053 – 77054,  77061 - 77067 | Breast Screening |
| **QTY** | **ULTRASOUND** | |
|  | 76813 - 76817 | Other Fetal Evaluations |
|  | 76536 - 76800 | Neck, Thorax, Abdomen & Spine |
|  | 76830 - 76873 | Male & Female Genitalia |
| **QTY** | **DEXA SCAN** | |
|  | 77080 - 77081 | Dual Energy X-ray Absorptiometry |

|  |  |  |
| --- | --- | --- |
| **QTY** | **OTOLARYNGOLOGY/ENT** |  |
|  | 69210 | Cerumen Removal |
|  | 31231 | Nasal Endoscopy |
|  | 92511 | Nasopharyngoscopy |
|  | 30901 | Cauterization of Epistaxis |
|  | 69200 | Removal of Foreign Body in Ear |
|  | 69420 | Myringotomy |
|  | 92552 | Pure Tone Audiometry |
|  | 92557 | Comprehensive Audiometry |
|  | 92567 | Tympanometry |
|  | 10021 | Fine Needle Aspiration |
|  | 95992 | Epley Maneuver |
| **QTY** | **LAB** |  |
|  | 81015 | UA Microscopic |
|  | 81000 | UA Dipstick |
|  | 81025 | Urine Pregnancy Test |
| **QTY** | **OB CARE** |  |
|  | 59400 | Total OB Care (w/2 utz) |
|  | 76801 - 76817 | Other Fetal Evaluations |
| **QTY** | **OPTHAMOLOGY** |  |
|  | 92002 - 92004 | Eye Exam New Patient |
|  | 92012 - 92014 | Eye Exam & Tx. Established Pt. |
|  | 92134 | OCT for retina |
| **QTY PODIATRY** | | |
|  | 11720 | Debride Nail 1-5 |
|  | 11055 | Trim Skin Lesion |
|  | 11721 | Debride Nail 6 or more |
| **QTY** | **CARDIOLOGY** |  |
|  | 93306 | Transthoracic Echocardiogram (TTE) |
|  | 93000 | EKG |
| **QTY** | **SCREENING** |  |
|  | 45378 – 45382, 45385 | Colonoscopy Screening and Tumor/ Polyp Removal |
|  | G0105 or G0121 | Colorectal Screening |
|  | 84152, 84153, 84165 | Prostate Specific Antigen complexed |
|  | 52000 | Cystoscopy |
| **QTY** | **HOME HEALTH** |  |
|  | G0299-G0300 | Skilled Nurse Visit (RN or LVN) Evaluation |
|  | 52000 | Cystoscopy |

|  |  |  |
| --- | --- | --- |
| **QTY** | **MISCELLANEOUS** |  |
|  | 11010 | Debride skin at fx site |
|  | 11011 | Debride skin musc at fx site |
|  | 11042 | Debride skin tissue 20 SQ CM |
|  | 11043 | Debride musc/fascia 20 sq cm |
|  | 11044 | Debride Bone 20 sq |
|  | 11045 | Debride subq tissue add on |
|  | 11046 | Debride musc/fascia add on |
|  | 11047 | Debride bone add on |
|  | 11055 | Trim skin lesion |
|  | 11056 | Trim skin lesion 2 to 4 |
|  | 11057 | Trim skin lesion over 4 |
|  | 11102 | Tangntl bx skin single lesion |
|  | 11103 | Tangntl bx skin single eachsep/additional |
|  | 11104 | Punch bx skin single lesion |
|  | 11105 | Punch bx skin each sep/additional |
|  | 11106 | Incal bx skin single lesion |
|  | 11107 | Incal bx skin each sep/additional |

# Referring Provider Signature Date Referring Provider Phone # Fax#

**Print name**

This form does not guarantee payments by Imperial Insurance Companies, Inc. Responsibility for payment shall be subject to member’s eligibility, benefit limitations and the interpretations of benefits under applicable subrogation and coordination of benefit rules. This form is not considered valid if not signed by requested provider. Imperial Insurance Companies requires a copy of this direct referral form to be submitted with the claim for payment. Services must be rendered by an Imperial Insurance Companies contracted provider. 2018 0701