

Direct Access Referral Form

Complete all sections of the form and give the original to the member. No additional authorization is needed. Retain copy in patient records.

***Member Information***

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

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£

**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 #**

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# 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