



REFERRAL REQUEST FORM

STEP 1: Select the request type (Required)

OUTPATIENT INPATIENT / FACILITY

STEP 1A: Choose the priority level (Required)

(*If Urgent is selected, provide clinical justification in the space provided next to the urgent option.)

STANDARD URGENT

STEP 2: Send the fax to the appropriate number (Required)

OUTPATIENT FAX: (214) 452-1905 INPATIENT / FACILITY FAX: (214) 452-1906

Referring Provider Phone # Fax # Date Submitted

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

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 IHMG 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. National Drug Code (NDC): (The NDC of the requested medication is required for proper adjudication and billing purposes. Requests submitted without the NDC will be considered incomplete and may result in processing delays or denials.)