PRE-AUTHORIZATION AND REFERRAL FORM

Pre-authorization needs to be received before the referral appointment.
All fields are mandatory and require completion for processing.

Uploading additional clinical documentation: ☐ Yes ☐ No   Priority: ☐ Standard ☐ Expedited ☐ Post Service

PATIENT INFORMATION

Last Name	First Name	Group Number
Date of Birth	ID Number	Today's Date

OUT-OF-NETWORK SPECIALTY/FACILITY

Full Name			Tax ID
NPI	Specialty		
Address	City	State	Zip Code
Phone Number	Fax Number		
Diagnosis			ICD-10
Procedure			CPT
(Please include office/visit notes on the next page of this form that will provide additional history related to this referral.)			

REQUESTING PHYSICIAN INFORMATION

Date	Physician Requesting Referral		
Phone Number	Fax Number		
Address of Requesting Physician	City	State	Zip Code
Tax ID	NPI	Physician's Signature	
Are you the Primary Care Office? ☐ Yes ☐ No	Person completing this form		

OTHER INFORMATION

Service Requested ☐ Office Visit ☐ Inpatient ☐ Outpatient ☐ Ambulatory surgery	☐ Other
☐ Consultation and Evaluation	Date of service (if known)
☐ Second Opinion	Date of Service (if known)
☐ Treatment/Procedure/Test	Specify code
☐ Patient Requested Specialist/specialty and/or out-of-network visit not necessary	

An updated plan of care and progress notes must be submitted with request for continued services.

A pre-authorization does not guarantee payment or authorize coverage for services not covered through the member's benefit plan. Claims are subject to review upon receipt of the claim/documentation.

OFFICE/VISIT NOTES