MEDICAL GROUP REFERRAL: Must be filled out completely in order to process

☐ Hemet	**Authorization Fax #: (888) 359-3583**	**DME/Home Health Fax #: (888) 359-3580**
☐ FamilySeniors	**Authorization Fax #: (888) 359-3582**	**DME/Home Health Fax #: (888) 359-3580**
☐ Menifee	**Authorization Fax #: (888) 359-3582**	**DME/Home Health Fax #: (888) 359-3580**
☐ Temecula	**Authorization Fax #: (888) 681-5925**	**DME/Home Health Fax #: (888) 359-3580**

☐ **Faxed to PCP** ☐ **Not On Web** ☐ **Web Reference**_____ ☐ **Routine**

☐ **Expedited (MUST MEET CMS GUIDELINES: Seriously jeopardizing the life or health of the member or member's ability to regain maximum function)**

PATIENT NAME LAST	FIRST	MI	BIRTHDATE (Mo/Day/Yr)
COMPLETE ADDRESS	CITY	STATE	ZIP
PATIENT PHONE NUMBER	PATIENT ID#	INSURANCE	

FROM		**REFERRAL TO**	
REQUESTING PHYSICIAN	PHYSICIAN SIGNATURE	SPECIALIST/FACILTY	
ADDRESS		ADDRESS	
CITY STATE ZIP		CITY STATE ZIP	
PHONE	FAX NUMBER	PHONE	FAX NUMBER
CONTACT PERSON	DATE	CONTACT PERSON	

PLEASE ATTACH CONSULTATIONS, LABS, X-RAY REPORTS AND OTHER DOCUMENTATION TO SUPPORT THE MEDICAL NECESSITY OF REFERRAL

☐OFFICE ☐OUT-PATIENT ☐IN-PATIENT ☐DME ☐HOME HEALTH HEIGHT_____ WEIGHT_____

NAME OF FACILITY	DATE OF PROCEDURE
DIAGNOSIS	ICD-10 CODE
PROCEDURE REQUESTED	CPT CODE
CLINICAL SYMPTOMS	

THIS SECTION MUST BE COMPLETED BY REQUESTING PHYSICIAN WHEN REFERRING OUTSIDE OF PREFERRED CAPPED PROVIDERS OR SPECIALISTS. MEDICAL REASON MUST BE STATED.

ATTACHED MEDICAL RECORDS MUST SUPPORT EXPEDITED REQUEST: ☐ **PHYSICIAN NOTES** ☐ **LABS** ☐ **RADIOLOGY** ☐ **CONSULTS**

UPON ACCEPTANCE OF REFERRAL AND TREATMENT OF THE PATIENT, PHYSICIAN/PROVIDER AGREES TO ACCEPT IPA CONTRACTED RATES. THIS REFERRAL/AUTHORIZATION VERIFIES MEDICAL NECESSITY ONLY. PAYMENTS FOR SERVICES ARE DEPENDENT UPON THE PATIENT'S ELIGIBILITY AT THE TIME SERVICES ARE RENDERED.

AUTHORIZATION VALID 90 DAYS FROM DATE OF APPROVAL/PENDING PATIENT ELIGIBILITY.

Fax completed referral form with all medical documentation to the UM Department.