



Referral Form

866-406-0937/602-778-3330 - Phone
602-778-3331 - Fax

DATE OF REQUEST: _____

PATIENT NAME:		ADDRESS:	
PHONE:	CITY:	STATE:	ZIP:
PATIENT ID NUMBER:		DOB:	AGE:
LEGAL GUARDIAN:		ADDRESS:	
PHONE NUMBER:	CITY:	STATE:	ZIP:
Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No		Other Insurance:	

Requesting Provider

Requesting Physician: _____ Name of Person Completing Form: _____

Phone Number: _____ Please fax consulting notes to PCP at: _____

Diagnosis: _____ **ICD-9:** _____ **CPT Code(s):** _____ **HCPC Code(s):** _____

Receiving Provider

Referring To: _____ Frequency: _____ Duration: _____

Address: _____ Phone Number: _____

Describe symptoms, duration, tried and/or failed treatment, relevant lab, diagnostic test (if possible please fax in supporting documentation with request):

If member is determined to be ineligible on date of service, the member may be responsible for these services. To ensure proper payment for services rendered, receiving provider must verify eligibility on the date of service.