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| This form is for services requiring health plan review. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **1. Referrals** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | (To be completed by IEHP) | | | | | | | | | | | | | | | | | | | | | | |
| ❑ | **Expedited** - Decision w/in 72 hours | | | | | | | | | | | | **Auth/Tracking Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | |
| ❑ | **Routine** | | | | | | | | | | | | **Auth/Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | |
| ❑ | **Patient Requested** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| ❑ | **Retro** | | | | | ❑ | **CPO Services** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| ❑ | **CBAS** | | | | |  |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| **2. General Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Member Name (please print) | | | | | | | | | | | | | | | DOB | | | | | | | | | | | ID # | | | | | | | | | |
| Plan *(select one)* | | ❑ | Medi-Cal | | | | | | | ❑ | Non-State Programs | | | | | | | | ❑ | | Open Access | | | | | | | | | | ❑ | | | Medicare | |
| Address | | | | | | | | City | | | | | | | | | | | | | | | | Zip | | | | | | Phone | | | | | |
| Diagnosis (Required) | | | | | | | | | | | | | | | | | | | | | | | | | **Diagnosis Code (REQUIRED)** | | | | | | | | | | |
| Clinical justification for referral and description of procedure requested if any (required) (attach clinical information). When requesting services out-of-network, please provide documentation of failed attempts at in-network providers/facilities. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Referred to (must refer to a specialist within network) | | | | | | | | | | Specialty: | | | | | | | | NPI#: | | | | | | | | | | | Phone | | | | | | |
| Address: | | | | | | | | | | City: | | | | | | | | | | | | Zip | | | | | | | Fax | | | | | | |
| Referring Provider (please print) | | | | | | | | | | | | | | | | | | Phone | | | | | | | | | | Fax | | | | | | | |
| Address | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | Zip | | | | | | |
| Referring Provider Signature (REQUIRED) | | | | | | | | | | | | | | NPI# | | | | | | | | | | | | | | | Date | | | | | | |
| **3. Service Requested** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Service Requested *(check one)* | | | | ❑ | Consult | | | | ❑ | | Follow-up | | ❑ | | | DME | | | | ❑ | | | Home Health | | | | | | | ❑ | | | Other | | |
| Service  Location/Facility: | | | | | | | | | | | | | ❑ | | | Office | | | | ❑ | | | Outpatient | | | | | | | ❑ | | | Inpatient | | |
| Procedure Requested (Submit supportive documentation with the claim to justify the Evaluation and Management (E & M) code if this service will occur the same day as the procedure.) | | | | | | | | | | | | | | | | | | | | | | | **CPT Code**  **(REQUIRED)** | | | | | | | | | | | | |
| Facility Address | | | | | | | | | | | | Phone | | | | | | | | | | | Fax | | | | | | | | | | | | |
| **4. Completed by IEHP** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date Additional  Information Required: | | | | Date Additional  Information Received: | | | | | | | | | | | ❑ | | Approved | | | | | | ❑ | | | | Modified | | | | | ❑ | | | Other |
| Assigned IPA: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical Reviewer Comments | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical Reviewer Signature (Circle Title: MD, DO, RN, LVN, Coordinator) | | | | | | | | | | | | | | | Date | | | | | | | | Criteria utilized in making this decision is available upon request by calling IEHP (866) 725-4347. | | | | | | | | | | | | |
| Upon acceptance of referral and treatment of the Member, the Physician/Provider agrees to accept IEHP contracted rates. This referral/authorization verifies medical necessity only. Payments for services are dependent upon the Member’s eligibility at the time services are rendered. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Notice: This facsimile contains confidential information that is being transmitted to and is intended only for use of the recipient named above. Reading, disclosure, discussion, dissemination, distribution, or copying of this information by anyone other than the named recipient or his or her employees or agents is strictly prohibited. If you have received this facsimile in error, please immediately destroy it and notify us by telephone at **(866) 725-4347.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |