INJECTABLE REFERRAL FORM

St. Vincent IPA Medical Corporation
Fax: (562) 924-1453
Phone: (562) 860-8771

APPLICABLE COPAY	AUTHORIZATION NUMBER

Date of Referral Request: _____/_____/_____ ☐ **Emergent** ☐ **Routine** ☐ **Urgent**

Patient Name (First, MI, Last): ____________________
Address: ____________________ City: ____________ ST: ________ Zip: ________
Date of Birth: _____/_____/_____ Phone: ____________________ Patient ID#: ____________________
Health Plan: ____________________

Referred From:
MD Office Contact Name: ____________________
Provider Name: ____________________
PCP/Specialty: ____________________
Phone: ____________________
Fax: ____________________
SIGNATURE OF REFERRING PROVIDER:

____

(Mandatory - Will not be processed without signature)

*Diagnosis: ____________________
____
*ICD 9: ____________________
____
Reason for Referral: ____________________
____
____
____
Additional notes attached: ☐ Yes ☐ No

Verbal notification to member of approval is required within 2 business days.
Member notified - Date:___________ Time:__________ Notified by:___________

If drug to be administered in office, office visit/administrative CPT code must accompany J code, if applicable.
Office Visit/Admin Code: ____________

Drug Name: ____________________
J Code: ____________________
Dosage: ____________________
Duration of treatment: ____________________
Frequency: ____________ Route: SQ IM

Drug Name: ____________________
J Code: ____________________
Dosage: ____________________
Duration of treatment: ____________________
Frequency: ____________ Route : SQ IM

Drug Name: ____________________
J Code: ____________________
Dosage : ____________________
Duration of treatment : ____________________
Frequency: ____________ Route : SQ IM

Drug Administered By:
☐ **Home Health** ☐ **Patient** ☐ **Physician**

- - - - - - - - - - UM STAFF ONLY - - - - - - - - - -

Benefits Verified By: ____________________
☐ Authorize Date ____________ ☐ Pending Date ____________
☐ Denied Date ____________ ☐ Not a covered benefit.
☐ Modified Date ____________
Comments: ____________________
____
UM Signature: ____________________ Date: ____________
Date PCP Notified: ____________________

Referred To:
Vendor: ____________________
Phone: ____________________ Fax: ____________________

Deliver To : ____________________
Address : ____________________
City: ____________ ST: ________ Zip: ________
Phone: ____________________

Certification does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitations provisions and exclusions. This certification is good for ninety (90) days from approval date.

Updated: 1/31/03