REFERRAL FORM

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

APPLICABLE COPAY	AUTHORIZATION NUMBER

Date of Referral Request: _____/_____/_____

☐ **Routine** ☐ **Urgent** ☐ **Emergent**

☐ **Specialist Request** ☐ **PCP Request**

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

Patient Name: (First, MI, Last) _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/_____ Phone: _____ Patient ID#: _____

Health Plan: _____

PCP Name: _____ Tel #: _____ Fax #: _____

Date of Last PCP Visit: _____ Date of Last Specialist Visit: _____

MD Office Staff Contact Name: _____ **Specialty Requested:**

MD Asking for Request: _____ _____

Tel #: _____ Fax #: _____

SIGNATURE OF REQUESTING PROVIDER:
(MANDATORY – WILL NOT BE PROCESSED WITHOUT SIGNATURE) _____

∴Diagnosis: _____ ICD-9: _____

ICD-9: _____

Procedure/Service Requested: _____ CPT CODE: _____

CPT CODE: _____

CPT CODE:

Place of Service:	☐ **Office**	☐ **Out-Patient**	☐ **In-Patient**	**Name Facility:**_____

Reason for REFERRAL: _____

Attachment	
Notes:	
Lab:	
EKG/EEG:	
X-Ray	
Other:	

FOR USE BY ST. VINCENT IPA MEDICAL CORPORATION UM STAFF ONLY

☐ Authorize Date: _____ ☐ Pending Date: _____ ☐ Modified Date: _____

☐ Denied Date: _____ ☐ Not a covered benefit. ☐ T P L ☐ Alternate Treatment Plan

Comments/Remarks: _____

UM Signature: _____ **Date:** _____

Date PCP Notified: _____ **Please notify member today of referral status.**

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. Referring providers may request a copy of the UM criteria or discuss their request with the IPA physician reviewer at any time. Your UM Case Management or Referral Coordinator will facilitate your request.

∴This section must be reviewed by physician prior to submission.

Revised: 05/19/03