



DIRECT REFERRAL
Electronic Claims Submission Use
Change Healthcare Submitter I.D.: PHP 95411 PHC-CA: 95422



Patient Name: _____ **DOB:** _____

Current Address: _____ **Phone Number: ()** _____

Member ID: _____

Diagnosis: _____ **Diagnosis Code:** _____

| Provider/Specialist | Address & Telephone Number | Appointment Date & Time |
|---------------------|----------------------------|-------------------------|
| | | |

In-Network PCP Name: _____ **Signature:** _____ **Date:** _____

The specialty consultation services listed below can be referred directly to the specialist ***without a prior authorization number***. Your patients must see ***in-network*** providers/physicians and utilize contracted facilities shown on your current provider roster. Please give this direct referral form to your patient to make the appointment and ask that he or she bring this form to the requested specialist/facility. **Procedures such as, but not limited to, surgeries, colonoscopies, imaging guided procedures and device placements require prior authorization.**

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| <p>Cardiology Office Evaluation Follow-Up Visit(s) x 2 EKG</p> <p>Dermatology Office Evaluation Follow-up Visit(s) x 2 Biopsy (punch and shave) Skin Cryotherapy</p> <p>Gastroenterology Initial Consultation Follow-up Visit(s) x 2 Screening Colonoscopy for <i>members age 50+</i></p> <p>General Surgery Initial Consultation Follow-Up Visit(s) x 2</p> <p>Hematology/Oncology Initial Consultation Follow-Up Visit(s) x 2</p> <p>Neurology Initial Consultation Follow-Up Visit(s) x 2</p> <p>Ophthalmology Initial Consultation, Yearly Diabetic Eye Exam Follow-Up Visit(s) x 2</p> <p>NOTE: All lab work must be referred to LabCorp.</p> | <p>Optometry (verify benefits) Initial Consultation Routine Eye Exam – one per year or change in Rx (verify benefits) Glasses/Frames/Lens (verify benefits) 92015 Refraction (verify benefits) Z2930 Dispensing (verify benefits)</p> <p>Orthopedic Initial Consultation, including X-rays in office, if required Follow-Up Visit(s), including X-rays in office, if required x 2</p> <p>Pain Management Initial Consultation, Follow-up Visit(s) x 2</p> <p>Prior Authorization Podiatry Initial Consultation, including flat X-rays in office, if required Follow-Up Visit(s), including flat X-rays in office, if required x 2</p> <p>Urology Initial Consultation Follow-Up Visit(s) x 2</p> <p>Radiology* – Must use contracted facilities only. flat plate X-ray of: _____ Ultrasound of: _____ Mammogram/Breast Ultrasound</p> <p>* CT scans, MRI, PET, Bone Density scans and nuclear imaging require prior authorization.</p> |
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- Eligibility:** Member must be eligible at the time of visit. To verify eligibility for PHP (HMO SNP) (Medicare Advantage and Prescription Drug Plan) and PHC California (Medi-Cal Managed Care Plan) call **(800)263-0067**.
- Benefits:** Member must have appropriate benefit level at the time of visit. Provider of service must verify benefits.
- Referring Provider:** Must be an in-network referring Primary Care Physician (PCP) and Direct Referral Form must be signed by the referring PCP.
- Rendering Provider:** The provider to whom member is referred must be an in-network provider and **utilize contracted facilities**.
- Claims:** Referring provider **Box 17 & 17 B** on CMS 1500 Form must be populated with referring PCP, provider name and NPI, claims without referring provider will be denied.
- Time:** This referral is effective for ninety (90) days from the date issued for initial and two (2) follow-up visits. **Additional visits, or visits after 90 days, require prior authorization.**