DIRECT REFERRAL

No authorization number is required for payment.
**Electronic Claims Clearinghouse: Change Healthcare; Submitter
I.D.: 95422**

Patient Name: _____ **DOB:** _____

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

Member ID: _____

Diagnosis: _____ **Diagnosis Code:** _____

Provider/Specialist	Address & Telephone Number	Appointment Date & Time

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.**

Cardiology 　Office Evaluation　　Follow-Up Visit(s) x 2 　EKG **Dermatology** 　Office Evaluation　　Follow-up Visit(s) x 2 　Biopsy (punch and shave)　Skin Cryotherapy **Gastroenterology** 　Initial Consultation Follow-up Visit(s) x 2 　Screening Colonoscopy for *members age 50+* **General Surgery** 　Initial Consultation 　Follow-Up Visit(s) x 2 **Hematology/Oncology** 　Initial Consultation　　Follow-up Visit(s) x 2 **Neurology** 　Initial Consultation　　Follow-Up Visit(s) x 2 **Ophthalmology** 　Initial Consultation, Yearly Diabetic Eye Exam 　Follow-Up Visit(s) x 2 ***NOTE: All lab work must be referred to <u>LabCorp.</u>***	**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) **Orthopedic** 　Initial Consultation, including X-rays in office, if required 　Follow-Up Visit(s), including X-rays in office, if required x 2 **Pain Management** 　Initial Consultation, Follow-up Visit(s) x 2 **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 **Urology** 　Initial Consultation　　Follow-Up Visit(s) x 2 **Radiology* – *Must use contracted facilities only.*** 　flat plate X-ray of: _____ 　Ultrasound of: _____ 　Mammogram/Breast Ultrasound 　* CT scans, MRI, PET, Bone Density scans and nuclear imaging 　　**require prior authorization.**

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.

Signature: Direct Referral Form must be signed by the referring primary care provider.

Provider: The provider to whom member is referred must be an in-network provider and **utilize contracted facilities**.

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.**