This space for plans requiring Pre-authorization

REFERRAL FORM

THIS FORM IS NOT AN ASSURANCE OF BENEFITS

NAME OF HEALTH CARE PLAN OR INSURER:_____

Patient's Name:_____Date of Birth:_____

Insured's Name: _____

ID Number: _____Group Number (if required): _____

If referred to:

Name of consultant _____ Specialty: _____
Address: _____
Phone Number: _____ Plan provider ( ) Non-provider ( ) (check one)

PRE-AUTHORIZATION MUST BE OBTAINED FROM HEALTH PLAN WHEN REQUIRED.

PAYMENT PROCEDURE: Consultant will be paid for eligible services according to the provisions of the patient's health care plan.

For the following diagnosis/problem: _____

Remarks:_____

Services requested (check all that apply): **Number of visits authorized (circle one):**

1. ( ) Evaluate and recommend treatment **1 2 3 4 5 Other** _____
2. ( ) Provide treatment for this disorder (any lab work or further referrals must be authorized by the primary care physician unless listed above)
3. ( ) Special procedures
4. ( ) Therapy
5. ( ) Surgery
6. ( ) Other _____
7. ( ) Documents attached (list): _____

COMMUNICATE THE ASSESSMENT AND RECOMMENDATION BACK TO THE PRIMARY CARE PHYSICIAN IN ALL CASES. If services beyond those authorized are needed, call the primary care physician.

_____

Primary Care Physician's Signature | NPI No. | Date Referral Authorized (Valid for 90 days)

Primary Care Physician **Typed, printed or stamped** **Name, Address, Phone**

UtahDOHHCF
Form 18 4/07