



SANTÉ COMMUNITY
PHYSICIANS

HMO REFERRAL FORM FOR IN-PLAN PROVIDERS

Direct Physician to Physician Contact is
Needed for Priority Scheduling

Urgency of Referral

Priority Routine

- | | | |
|--|---|--|
| <input type="checkbox"/> AARP Medicare Complete | <input type="checkbox"/> California Care (Blue Cross) | <input type="checkbox"/> Humana Gold Plus HMO & HMO SNP |
| <input type="checkbox"/> Aetna | <input type="checkbox"/> Cigna | <input type="checkbox"/> United Healthcare Signature Value |
| <input type="checkbox"/> Anthem Blue Cross Senior Secure | <input type="checkbox"/> Community Care Health Plan | <input type="checkbox"/> United Healthcare Medicare Solutions: Group Retiree |
| <input type="checkbox"/> Anthem Dual Advantage | <input type="checkbox"/> Health Net | <input type="checkbox"/> WellCare/Easy Choice |
| <input type="checkbox"/> Blue Shield 65 Plus | <input type="checkbox"/> Health Net Seniority Plus | |
| <input type="checkbox"/> Blue Shield Access Plus | | |

P.O. Box 792, Fresno, CA 93712-0795 Phone • (559) 228-5430 • (800) 652-2900

PATIENT INFORMATION

PATIENT NAME		GENDER <input type="checkbox"/> M <input type="checkbox"/> F	DOB	I.D.# (Include SS# if different)	GROUP #
INSURANCE CARD EFF. DATE	PATIENT ADDRESS			PATIENT DAYTIME PHONE #	
OTHER INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO Name of Other Carrier:	ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	MVA <input type="checkbox"/> YES <input type="checkbox"/> NO	JOB RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF INJURY	
WORKERS COMP CARRIER	WORKERS COMP ADDRESS			WORKERS COMP PHONE #	

REFERRING PRIMARY CARE PHYSICIAN INFORMATION

PCP OF RECORD _____	SIGNATURE	
PCP ON CALL _____		
CONTACT PERSON	PHONE #	FAX #

REFERRED TO (SPECIALIST) INFORMATION

<ul style="list-style-type: none"> ▪ NO REFERRAL FORM NEEDED FOR LAB, X-RAY, PHYSICAL THERAPY ▪ USE PRIOR AUTHORIZATION FORM FOR OUT-OF-PLAN REFERRALS & SERVICES REQUIRING PRIOR AUTHORIZATION 		
SPECIALIST NAME (Print)	PHONE#	ADDRESS

CHECK (✓) IF REFERRING TO: Diabetes Care Center Cardiac Rehab Pulmonary Rehab Dietary Consultation

REFERRAL INFORMATION

DIAGNOSIS	ICD-10 CODE
DATE OF REQUEST	# OF VISITS (Valid for 180 Days)
<input type="checkbox"/> CONSULTATION ONLY <input type="checkbox"/> CONSULTATION AND TREATMENT <input type="checkbox"/> REFERRAL FOR TREATMENT	

SEE REFERRAL GUIDE AND ATTACH APPROPRIATE MEDICAL RECORDS TO EXPEDITE REFERRAL

- | | | |
|--|--|--|
| <input type="checkbox"/> PROGRESS NOTES ATTACHED | <input type="checkbox"/> CONSULTANT'S NOTES ATTACHED | <input type="checkbox"/> NOTES WITH SPECIFIC FINDINGS ATTACHED |
| <input type="checkbox"/> EKG ATTACHED | <input type="checkbox"/> LAB REPORT ATTACHED | <input type="checkbox"/> X-RAY REPORT ATTACHED |
| <input type="checkbox"/> IMAGING STUDY REPORT ATTACHED | <input type="checkbox"/> MEDICATIONS LIST ATTACHED | <input type="checkbox"/> CARDIAC RELATED STUDIES ATTACHED |
| <input type="checkbox"/> IMMUNIZATION RECORD ATTACHED | <input type="checkbox"/> Other _____ | |

Mail copy to Santé at P.O. Box 792, Fresno, CA 93712-0792

Mail or fax a copy to specialist

Place a copy in patient's chart

- THIS REFERRAL DOES NOT GUARANTEE PAYMENT OF NON-COVERED SERVICES
- THIS REFERRAL DOES NOT GUARANTEE PAYMENT IF PATIENT IS NOT ELIGIBLE