



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"/> United Healthcare Signature Value |
| <input type="checkbox"/> Aetna | <input type="checkbox"/> Cigna | <input type="checkbox"/> United Healthcare Medicare Solutions: Group Retiree |
| <input type="checkbox"/> Aetna Medicare Advantage Plan | <input type="checkbox"/> Health Net | |
| <input type="checkbox"/> Blue Shield Access Plus | <input type="checkbox"/> Humana Medicare Advantage | |

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

<p>▪ NO REFERRAL FORM NEEDED FOR LAB, X-RAY, PHYSICAL THERAPY</p> <p>▪ USE PRIOR AUTHORIZATION FORM FOR OUT-OF-PLAN REFERRALS & SERVICES REQUIRING PRIOR AUTHORIZATION</p>		
SPECIALIST NAME (Print)	PHONE#	ADDRESS
CHECK (✓) IF REFERRING TO: <input type="checkbox"/> Diabetes Care Center <input type="checkbox"/> Cardiac Rehab <input type="checkbox"/> Pulmonary Rehab <input type="checkbox"/> Dietary Consultation		

REFERRAL INFORMATION

DIAGNOSIS	ICD-9 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...