

DIRECT REFERRAL FORM

Instructions: Direct referrals to In-Network / In-Area specialists do not require prior authorization.

After completing this form, the referring provider can send a copy to the specialist and schedule the member for his / her specialist appointment.

** If this is an Out-of-Network / Out-of-Area referral, please utilize the Prior Authorization Treatment Request Form **

PATIENT INFORMATION				
Patient Name:				Date:
Last			First	
Mailing Address:			_ City:	Zip:
CIN Number:	П	☐ F D.O.B:	Age:	Patient Phone:
Name of PCP:			_ Facility:	
Address:			Phone:	
ORDERING PROVIDER IN-NETWORK			□ OUT-OF-AREA	
Provider Name:			Phone:	Fax:
Address:			Speciality:	
City:	State:	Zip:	TIN:	NPI:
Office Contact:				
REFERRAL SPECIALIST INFORMATION				
Provider Name:			Phone:	Fax:
Address:			Speciality:	
City:	State:	Zip:	TIN:	NPI:
Office Contact:				
(Note: If a prior authorization is required for the specific treatment indicated, a Prior Authorization Treatment Request Form submission will be required prior to treatment.)				
Provider Signature:				Date Issued:

** PROVIDER: Eligibility Must Be Verified At Time Services Are Rendered. **