



Referral Form

This form is to be faxed to the Receiving Provider or sent with the member

DATE OF REQUEST: _____

Referral Form Expires 90 days from the date of request.

PATIENT NAME:		ADDRESS:	
PHONE:	CITY:	STATE:	ZIP:
PATIENT ID NUMBER:		DOB:	AGE:
LEGAL GUARDIAN:		ADDRESS:	
PHONE NUMBER:	CITY:	STATE:	ZIP:
Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No		Other Insurance:	

Requesting Provider

Requesting Physician: _____ Name of Person Completing Form: _____

Phone Number: _____ **Please fax consulting notes to PCP at:** _____

Diagnosis: _____ **ICD-9:** _____ **CPT Code(s):** _____ **HCPC Code(s):** _____

Receiving Provider

Referring To: _____ # of visits: _____ Duration: _____

Address: _____ Phone Number: _____

Describe symptoms, duration, tried and/or failed treatment, relevant lab, diagnostic test (if possible please fax supporting documentation with referral):

Do not fax the referral form to SCAN Prior Authorization. For prior authorization requests use the Prior Authorization Request form.

If member is determined to be ineligible on date of service, the member may be responsible for these services. To ensure proper payment for services rendered, receiving provider must verify eligibility on the date of service.