SANTÉ PHYSICIANS

HMO REFERRAL FORM
FOR IN-PLAN PROVIDERS

Direct Physician to Physician Contact is Needed for Priority Scheduling

Urgency of Referral

☐ **Priority** ☐ **Routine**

☐ **AARP Medicare Complete**
☐ **Aetna**
☐ **Blue Shield Access Plus**
☐ **Blue Shield 65 Plus**
☐ **Brand New Day**
☐ **California Care (Blue Cross)**
☐ **Cigna**
☐ **Community Care Health**
☐ **Health Net**
☐ **Health Net Healthy Heart**
☐ **Health Net Sapphire Premier**
☐ **United Healthcare Signature Value**
☐ **United Healthcare Medicare Solutions: Group Retiree**

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

PATIENT INFORMATION

PATIENT NAME	GENDER ☐ M ☐ F	DOB	I.D.# (Include SS# if different)	GROUP #

INSURANCE CARD EFF. DATE	PATIENT ADDRESS	PATIENT DAYTIME PHONE #

OTHER INSURANCE ☐ YES ☐ NO Name of Other Carrier:	ACCIDENT ☐ YES ☐ NO	MVA ☐ YES ☐ NO	JOB RELATED? ☐ YES ☐ NO	DATE OF INJURY

WORKERS COMP CARRIER	WORKERS COMP ADDRESS	WORKERS COMP PHONE #

REFERRING PRIMARY CARE PHYSICIAN INFORMATION

PCP OF RECORD _____

PCP ON CALL _____

SIGNATURE

CONTACT PERSON	PHONE #	FAX #

REFERRED TO (SPECIALIST) INFORMATION

- **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)	☐ CONSULTATION ONLY ☐ CONSULTATION AND TREATMENT ☐ REFERRAL FOR TREATMENT

SEE REFERRAL GUIDE AND ATTACH APPROPRIATE MEDICAL RECORDS TO EXPEDITE REFERRAL

☐ **PROGRESS NOTES ATTACHED** ☐ **CONSULTANT'S NOTES ATTACHED** ☐ **NOTES WITH SPECIFIC FINDINGS ATTACHED**
☐ **EKG ATTACHED** ☐ **LAB REPORT ATTACHED** ☐ **X-RAY REPORT ATTACHED**
☐ **IMAGING STUDY REPORT ATTACHED** ☐ **MEDICATIONS LIST ATTACHED** ☐ **CARDIAC RELATED STUDIES ATTACHED**
☐ **IMMUNIZATION RECORD ATTACHED** ☐ **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