Direct Physician to Physician Contact is Needed for Priority Scheduling

Urgency of Referral

☐ **Priority** ☐ **Routine**

SANTÉ PHYSICIANS

HMO REFERRAL FORM
FOR IN-PLAN PROVIDERS

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**	☐ **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 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