SANTÉ PHYSICIANS

MEDI-CAL MANAGED CARE
REFERRAL FORM

(Direct Physician to Physician contact is needed prior to scheduling)	**Urgency of Referral**	❑ Priority	❑ Routine
Health Plan	❑ Anthem Blue Cross	❑ Health Net	

PATIENT INFORMATION

PATIENT NAME	Gender ☐M ☐F	D.O.B.	I.D. # (Include SS# if different)	INS. CARD EFF. DATE

ADDRESS	CITY	STATE	ZIP	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	☐ CONSULTATION NOTES ATTACHED	☐ NOTES WITH SPECIFIC FINDINGS ATTACHED
☐ EKG ATTACHED	☐ LAB REPORT ATTACHED	☐ X-RAY REPORT ATTACHED
☐ IMAGING STUDY REPORT ATTACHED	☐ MEDICATION LIST ATTACHED	☐ CARDIAC RELATED STUDIES ATTACHED
☐ IMMUNIZATION RECORD ATTACHED	☐ Other _____	

Mail or fax a copy to Specialist
Place a copy in patients chart

- THIS REFERRAL DOES NOT GUARANTEE PAYMENT OF NON-COVERED SERVICES
- THIS REFERRAL DOES NOT GUARANTEE PAYMENT IF PATIENT IS NOT ELIGIBLE