

DIRECT REFERRAL AUTHORIZATION FORM

Instructions: Direct referrals to In-Network/In-Area specialists do not require preauthorization. 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 Preauthorization Treatment Request Form **

PATIENT INFORMATION				
Patient Name:			Date:	
L	ast		First	
Mailing Address:			City:	Zip:
CIN Number:	D	I □ F D.O.B: _		ge: Patient Phone:
Name of PCP:			Facility:	
Address:			Phone:	
ORDERING PROVIDER	□ IN NE	TWORK	OUT OF ARI	EA .
Provider Name:			Phone:	Fax:
Address:			Speciality:	
City:	State:	Zip:	TIN:	NPI:
Office Contact:				
REFERRAL SPECIALIST INFO	DRMATION			
Provider Name:			Phone:	Fax:
Address:			Speciality:	
City:	State:	Zip:	TIN:	NPI:
Office Contact:				
Description Of Authorization	Limitation: _			
Consultation Only			Consultation a	nd Treatment
(Note: If a preauthorization is require	d for the specific	treatment indicated,	a Preauthorization Req	uest Form submission will be required prior to treatment.)
Authorization Effective Date	5			
Authorization is valid from:			through	(dates).
Provider Signature:				Date Issued:

^{**} PROVIDER: Authorization Does Not Guarantee Payment. Eligibility Must Be Verified At Time Services Are Rendered. **