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*****REQUESTS NOT CERTIFIED AS URGENT WILL BE PROCESSED AS ROUTINE*****

LOS ANGELES MEDICAL CENTER IPA

Referral Request Form

Tel (951) 280-7700 Fax (951) 280-8214

___ Medically Urgent – PHYSICIAN CERTIFICATION OF MEDICAL URGENCY IS MANDATORY

I _____ certify that this request is medically urgent due to the following reasons: _____
 (Print name of Physician)

MD Signature: _____

Referral number does not guarantee payment. Member must be eligible at time of service.

Patient Last Name					First Name			Gender		D.O.B.		Age		
Address						Phone				Subscriber ID # / ID #				
City, State, Zip						Health Plan				LOB:				
REFERRING PROVIDER								NPI #						
Name						Address								
Phone			Fax			Provider Signature			Date		Office Contact			
REQUESTED PROVIDER (Physician, Facility, Service)								NPI #						
Name						Address								
Phone			Fax			Comments								
PCP (If different from Referring Provider above)								NPI #						
Name			Office Contact			Phone			Fax					

Diagnosis						ICD-10 Code MANDATORY					
IMPORTANT-ATTACH ALL APPROPRIATE PROGRESS NOTES, LAB AND X-RAY RESULTS TO SUPPORT YOUR REQUEST.											
SERVICES REQUESTED – <u>Please Be Specific</u> (i.e., consult, follow-up, treatment, DME, etc.)											
Procedure Code (CPT) MANDATORY											

THE FOLLOWING MANDATORY INFORMATION MUST BE SUBMITTED TO SUPPORT YOUR REQUEST:											
1. DOCUMENTATION OF FAILED CONSERVATIVE TREATMENT – NOTES INCLUDING INITIAL TREATMENT AND FOLLOW UP CARE PROVIDED											
2. ALL IMAGING STUDIES AND LABS RELATED TO THE ABOVE DIAGNOSIS											
3. ALL PERTINENT PREVIOUS CONSULT REPORTS											
4. LIST OF MEDICATIONS USED TO TREAT THE ABOVE DIAGNOSIS											

Services Approved are Contingent on Eligibility, Benefits and Billing Guidelines.

Mail claims to: CAL CARE MEDICAL GROUP 2115 Compton Avenue Department 100, Corona, CA 92881-7273