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LAMC IPA Referral Request Form

Tel (951) 280-7893 Fax (951) 280-8200

☐ **Routine** ☐ **Medically Urgent - Reason** ___________________________ **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**			

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-9 Code **MANDATORY**

SERVICES REQUESTED – _Please Be Specific_ (i.e., consult, follow-up, treatment, DME, etc.)

Procedure Code (CPT) **MANDATORY**

THE FOLLOWING MANDATORY INFORMATON MUST BE SUBMITTED TO SUPPORT YOUR REQUEST:

- ☐ **DOCUMENTATION OF FAILED CONSERVATIVE TREATMENT – NOTES INCLUDING INITIAL TREATMENT AND FOLLOW UP CARE PROVIDED**
- ☐ **ALL IMAGING STUDIES AND LABS RELATED TO THE ABOVE DIAGNOSIS**
- ☐ **ALL PERTINENT PREVIOUS CONSULT REPORTS**
- ☐ **LIST OF MEDICATIONS USED TO TREAT THE ABOVE DIAGNOSIS**

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

Mail claims to: LAMC IPA 2115 Compton Avenue Department 100, Corona, CA 92881-7273