Referral Universe

MONTH: ______________________ **LOB:** ______________________ **IPA:** ______________________

IPA Auth/Tracking number	Member Name	IEHP ID Number	Member Date of Birth	Priority of Referral*	Authorization Type **	Date Request Received	Time Request Received (urgent requests)	Requesting/ Referring Provider	Requested Provider	Requested Provider Specialty	Service Requested	Service Category	Diagnosis	Was a timeframe extension taken?	If an extension was taken, date the Notice of Delay was issued to the Member	If an extension was taken, date the Notice of Delay was issued to the Provider	Referral Disposition/ Decision***	Reason for Denial/Modification/ Cancellation****	Decision date	Decision time (Urgent requests)	Date notice mailed to Member	Date Provider Notified	Date Effectuated*****	Decision Maker (if denied or modified)

* Priority of Referral: Urgent, Routine
** Authorization Type: Prospective, Retroactive, Concurrent
*** Referral Disposition/Decision: Approved, Modified/ Partially Approved, Denied, Cancelled, Carve-out
****Reason for denial/modification Not medically necessary, not a covered benefit, carve out, out of network, etc.
***** Date Effectuated Date of effectuation / when was the authorization available in the claims system