

1A. OPEN ACCESS TO OB/GYN SERVICES

Members can be referred for the following OB/GYN services without prior authorization:

- Consultation or follow-up (OB/GYN Only)
- Well-Woman Exam
- In office procedures to include: colposcopy, biopsy, repeat pap smear, insertion of an IUD.
- Tubal ligation
- Total OB Care (Members must deliver at an IEHP network hospital.)
- Members must be treated by an IEHP network specialist or a Family Planning Office.
- A contracted laboratory must be used for all laboratory testing (no prior authorization required.) Use of any other laboratory requires prior authorization.
- For more information regarding contracted providers, please call (866) 725-4347.

1B. REFERRALS

- Request to update a decided Auth Number _____

Type of Update:

- Redirection
 Code addition
 Extension
 Quantity Change
- EXPEDITED** - Decision w/in 72 hours (to be used when standard processing time frames may result in loss of life or limb)
- STANDARD PRESERVICE**
- STANDARD POSTSERVICE**
- PATIENT REQUEST**

2. GENERAL INFORMATION

Member Name (please print)

DOB

ID#

Plan (select one)

 Medi-Cal IEHP Covered Non-State Programs Open Access Medicare

Address

City

Zip

Phone

Diagnosis (Required)

ICD-10 Code (REQUIRED)

Clinical justification for referral and description of procedure requested if any (required) (attach clinical information)

Referred to (must refer to a specialist within network)

Specialty:

NPI#:

Phone

Address

City

Zip

Fax

Referring Provider Signature (REQUIRED)

NPI#:

Date

3. SERVICE REQUESTED

Service Requested (check one)

 Consult Follow-up DME Home Health Other

Service Location/Facility:

 Office Outpatient Inpatient

Procedure Requested (Submit supportive documentation with the claim to justify the Evaluation and Management (E & M) code if this service will occur the same day as the procedure.)

CPT Code (REQUIRED)

Facility Address:

Phone

Fax

4. COMPLETED BY IEHP

Date Additional Information Required:

Date Additional Information Received:

Approved

Modified

Other

Medical Reviewer Comments

Medical Reviewer Signature (Circle Title: MD, DO, RN, LVN, Coordinator)

Date:

Criteria utilized in making this decision is available upon request by calling IEHP (866) 725-4347.

UPON ACCEPTANCE OF REFERRAL AND TREATMENT OF THE MEMBER, THE PHYSICIAN/PROVIDER AGREES TO ACCEPT IEHP CONTRACTED RATES. This referral/authorization verifies medical necessity only. Payments for services are dependent upon the Member's eligibility at the time services are rendered.

FAX COMPLETED REFERRAL FORMS TO (909) 890-5751.
For BH referrals, please log on to the web portal at iehp.org

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