UM Referral Form

IEHP Inland Empire Health Plan

Date

1A. OPEN ACCESS TO OB/GYN SERVICES

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

a. Consultation or follow-up (OB/GYN only)
b. Well-Woman Exam
c. In-office procedures to include: colposcopy, biopsy, repeat pap smear, insertion of an IUD.
d. Tubal ligation
e. Total OB care (members must deliver at an IEHP network hospital)
f. Members must be treated by an IEHP network specialist or a family planning office.
g. A contracted laboratory must be used for all laboratory testing (no prior authorization required). Use of any other laboratory requires prior authorization.
h. For more information regarding contracted providers, please call **1-866-725-4347**.

1B. REFERRALS

☐ **Request to update a decisioned Auth Number** _____

Type of Update:

☐ Redirection
☐ Code addition
☐ Extension
☐ Quantity change

☐ **EXPEDITED -** Decision within 72 hours (to be used when standard processing time frames may result in loss of life or limb)

☐ **STANDARD PRESERVICE**

☐ **STANDARD POST-SERVICE**

☐ **PATIENT REQUEST**

1C. Is the member being referred to a provider outside of IEHP's provider network?

☐ Yes ☐ No

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 1-866-725-4347.

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