REFERRAL FORM:
Community Supports Services Date:

1A. CS Services: Member can be referred from PCP, BH provider, or Specialist	
❑ Recuperative Care (Medical Respite)	❑ Sobering Centers
❑ Short-Term Post-Hospitalization Housing	❑ Day Habilitation
❑ Housing Transition Navigation Services	❑ Personal Care and Homemaker Services
❑ Housing Deposits	❑ Respite Services
❑ Housing Tenancy & Sustaining Services	❑ Asthma Remediation
❑ Medically Supportive Food/Meals/Medically Tailored Meals	❑ Nursing Facility Transition/Diversion to Assisted Living Facilities
❑ Environmental Accessibility Adaptations (Home Modifications)	❑ Community Transition Services/Nursing Facility Transition to a Home

1B. Referrals

❑ **Request to update a decisioned auth** **Auth Number** _____

Type of Update: ❑ Redirection ❑ Code addition ❑ Extension ❑ Quality Change

2. General Information

Member Name (please print):				DOB:	ID #:
Plan (select one)	❑ Medi-Cal	❑ Healthy Kids	❑ 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:
Referring Provider (please print):			Phone:		Fax:
Address:		City:	Zip:		Phone:
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 supporting documents):			**CPT Code (REQUIRED):**		
Facility Address:		Phone:		Fax:	

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 1-909-890-5751.

For Community Supports referrals, please log on to the web portal at www.iehp.org