Inland Empire Health Plan

Standing Referral and Extended Access Referral to Specialty Care

Date of Request					
IPA or Medical Group			**Phone No.**		
Primary Care Provider's (PCP) Name					
Phone No.		**Fax No.**			
Requesting Provider's Name					
Phone No.		**Fax No.**			
Other Insurance					
Member Name		**Member ID**			
Phone No.		**DOB**		**Gender**	❑ M ❑ F
Address					
City		**State**		**Zip Code**	
Referred to (Physician Name)			**Specialty**		
Phone Number		**Fax No.**			
Primary Diagnosis			**ICD-10 Code**		
Secondary Diagnosis			**ICD-10 Code**		
When was the diagnosis first made?					
How many times has the patient been seen by the Specialist in the past year?					

PRACTITIONER TREATMENT PLAN (Please attach or complete this table.)			
# of Visits per 3 Months	**# of Visits per 6 Months**	**# of Visits per 9 Months**	**# of Visits per 12 Months**

Briefly describe what is anticipated from each visit:

IMPORTANT
• Additional information regarding the treatment plan may be requested from the Specialist, if necessary. If so, decision will be made within three (3) business days of receipt of the information. • Authorization remains valid only if the Member is eligible. • Payment is contingent upon the Member's eligibility at the time the service was rendered.