**REFERRAL FORM** **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 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 (866) 725-4347

## 1B. Referrals

❑ **REQUEST TO UPDATE A DECISIONED AUTH**

**AUTH NUMBER** _____

**Type of Update:**

❑ Redirection
❑ Code addition
❑ Extension
❑ Quantity Change

❑ **EXPEDITED –** DECISION WITHIN 72 HOURS

❑ **STANDARD PRE-SERVICE** –
MEDI-CAL DECISION WITHIN 5 BUSINESS DAYS
MEDICARE DECISION WITHIN 14 CALENDAR DAYS

❑ **STANDARD POST-SERVICE** –
MEDI-CAL DECISION WITHIN 30 CALENDAR DAYS
MEDICARE DECISION WITHIN 14 CALENDAR DAYS

❑ **PATIENT REQUEST** –
MEDI-CAL DECISION WITHIN 5 BUSINESS DAYS
MEDICARE DECISION WITHIN 14 CALENDAR DAYS

## 2. GENERAL INFORMATION

| Member Name (please print) | | | DOB | ID # |
|---|---|---|---|---|
| Plan *(select one)* | ❑ Medi-Cal | ❑ 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) (please attach clinical information)** | | | | |
| Referred to **(must refer to a specialist within network)** | Specialty: | | NPI#: | Phone |
| Address: | City: | | Zip | Fax |
| Referring Provider (please print) | | | Phone | Fax |
| Address | | | City | Zip |
| **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 | ❑ Denied | ❑ 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 REFERRALS RELATED TO BEHAVIORAL HEALTH, PLEASE FAX FORMS TO (909) 890-5763.**

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