

**OPHTHALMOLOGIST
REFERRAL FORM**



DATE: _____

1A. OPTOMETRY TO OPHTHALMOLOGY REFERRALS ONLY

1. Fax a copy to the Member's IPA.
2. Place a copy in Member's medical record.
3. Fax a final copy back to the referring Optometrist

1B. REFERRAL TYPE

- GENERAL OPHTHALMOLOGY
- RETINA SPECIALIST
- PEDIATRIC OPHTHALMOLOGY
- MEDICALLY URGENT
- ROUTINE – Decision in five (5) working days
- Patient Request

2. GENERAL INFORMATION

Member Name (please print)		DOB	ID #	
Plan (select one)	<input type="checkbox"/> Medi-Cal <input type="checkbox"/> DualChoice	Parent/Guardian/Caretaker name (REQUIRED)		
Address		City	Zip	Phone
Diagnosis			ICD-10 Code (REQUIRED)	
Clinical justification for referral (and description of procedure requested if any) *REQUIRED				
Referring Provider (please print)		Phone		Fax
Address		City		Zip
Referring Provider Signature (REQUIRED)		Office Contact Person		

3. COMPLETED BY IPA

Ophthalmologist Referred (please print)		Appointment Date	Phone	
Address		City	Zip	Fax
<input type="checkbox"/> Office <input type="checkbox"/> Outpatient	CPT Code (REQUIRED)			
Date Additional Information Requested:	Date Additional Information Received:	<input type="checkbox"/> Approved	<input type="checkbox"/> Modified	<input type="checkbox"/> Denied

Medical Reviewer Comments

IF YOU WOULD LIKE TO DISCUSS THIS DECISION WITH THE PHYSICIAN REVIEWER, PLEASE CONTACT THE IPA:

IPA NAME: _____ **Phone:** () - _____

Medical Reviewer Signature (Circle Title: MD, DO, OD, RN, LVN, Coordinator)	Date/Time	Criteria utilized in making this decision are available upon request by calling IEHP – Provider Relations at (909) 890-2054.
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UPON ACCEPTANCE OF REFERRAL AND TREATMENT OF THE MEMBER, THE PHYSICIAN/PROVIDER AGREES TO ACCEPT IPA 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.

NOTICE: This facsimile contains confidential information that is being transmitted to and is intended only for the use of the recipient named above. Reading, disclosure, discussion, dissemination, distribution, or copying of this information by anyone other than the named recipient or his or her employees or agents is strictly prohibited. If you have received this facsimile in error, please immediately destroy it and notify us by telephone at **(909) 890-2054.**

FAX COMPLETED REFERRAL FORMS TO THE MEMBER'S IPA.