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*)	☐ Medi-Cal ☐ 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

☐ Office ☐ Outpatient	**CPT Code (REQUIRED)**			
Date Additional Information Requested:	Date Additional Information Received:	☐ Approved	☐ Modified	☐ 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**.

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.

FAX COMPLETED REFERRAL FORMS TO THE MEMBER'S IPA.