STREAMLINED REFERRAL FORM C

SUBMIT FORM DIRECTLY TO PROVIDER

Citrus Valley Physicians Group
Phone: (855) 498-2633 | Fax: (760) 477-2925

TRACKING NUMBER
IPA USE ONLY

Date of Referral Request: _____/_____/_____ ☐ **Routine** ☐ **Urgent** ☐ **Emergent**

Patient Name: (First, Last) _____

Address: _____ City: _____ Zip: _____

Date of Birth: ____/____/_____ Phone: _____

Health Plan: _____ Patient ID#: _____

Referred From:

PCP: _____

Phone: _____

Fax: _____

Office Contact Name: _____

STREAMLINED LIST:

- ❑ **OPTHALMOLOGY – CA Eye Care Managed (ALL Regions)**
  Tel: (626) 305-9100 | Fax: (626) 305-9160
- ❑ **LABORATORY – Lab Corp (ALL Regions)**
  Tel: (800) 222-7566
- ❑ **MENTAL HEALTH – Cornerstone Behavioral Health**
  Regions 1, 2 & 3 Senior lines of business only
  Tel: (714) 282-9713 | Fax: (714) 282-8016

***REASON FOR REFERRAL:**

SIGNATURE OF PCP:

Certification does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions. This certification is good for sixty (60) days from approval date.

***This section must be reviewed by physician prior to submission.**

If you have any question as to whether a referral is needed, please contact UM Dept. at (855) 498-2633.

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