REFERRAL FORM A – PCP

TRACKING NUMBER
IPA USE ONLY

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

Date of Referral Request: _____/_____/_____

☐ **Member Request**

☐ **Routine** ☐ **Urgent** ☐ **Emergent**

Patient Name: (First, Last) ____________________

Address: ____________________ City: ____________________ Zip: __________

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

Health Plan: ____________________ Patient ID#: ____________________

Referred To: **ICD-10:**

Specialty Type: ____________________

Referred By: (PCP) ____________________ **Diagnoses:** ____________________

PCP office Contact : ____________________

PCP Phone: ____________________

PCP Fax: ____________________

SIGNATURE OF PCP:
(MANDATORY – WILL NOT BE PROCESSED WITHOUT MD SIGNATURE) ____________________

Procedures/services requested:	CPT CODE:
	CPT CODE:
	CPT CODE:
	CPT CODE:

Reason for REFERRAL: ____________________

Attachment(s)	
Notes:	
Lab:	
EKG/EEG:	
X-Ray	
Other:	

Place of Service: ☐ **Office** ☐ **Out-Patient** __________ ☐ **In-Patient** __________

FOR USE BY CITRUS VALLEY PHYSICIANS GROUP UM STAFF ONLY

☐ Authorize Date: __________ ☐ Pending Date: __________ ☐ Modified Date: __________

☐ Denied Date: __________ ☐ Not a covered benefit. ☐ T P L

Comments/Remarks: ____________________

UM Signature: ____________________ **Date:** __________

Date PCP Notified: ____________________ **◊Please notify member today of referral status.**

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