REFERRAL FORM B – Specialist

TRACKING NUMBER
IPA USE ONLY

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

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

Patient Name: (First, Last) _____

Address: _____ City: _____ Zip: _____

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

Health Plan: _____ Patient ID#: _____

Referred To: **ICD-10:**

Specialty Type: _____

Referred By: **Diagnoses:**

Requesting provider office contact Name **PCP's Name :**

Provider Phone: _____

Provider Fax: _____

SIGNATURE OF Physician:
(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