REFERRAL FORM P – Physical Therapy

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

TRACKING NUMBER
IPA USE ONLY

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: **United Therapy Network** **ICD-10:**

Specialty Type: Physical Therapy Diagnoses: (symptoms of problem)

Phone: (909) 890-9030 **Please check CVPG web site for more addresses**

Fax: (909) 890-4393 **Procedure/CPT Code:**

Referred By: (PCP) _____

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

Rationale/indications for Physical Therapy: (choose and circle appropriate response)
To improve function or to alleviate pain

Range of Motion Limitations: ☐ Severe/Contracture ☐ Moderate ☐ Minimal ☐ None

Strength Limitations (Weakness): ☐ Severe ☐ Moderate ☐ Minimal ☐ None

Functional Limitations: ☐ Severe, interfering with basic function ☐ Moderate, interfering with work/ADL
☐ Minimal ☐ None

Pain: Grade _____ Current treatment modalities _____

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.

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