Uniform Consultation Referral Form

1. Patient Information

Date of Referral:

Name (Last, First, MI)

Date of Birth: (MM/DD/YY) | Phone:

Member#:

Site #:

2. Carrier Information

Name:

Address:

Phone:
Fax:
Referral Number:

3. Primary or Requesting Provider:

Name: (Last, First, MI) | **Specialty:**

Institution / Group Name: | **Provider ID:** | **Provider ID #: 2 (If Required)**

Address: (Street #, City, State, Zip)

Phone Number: | **Facsimile / Data Number:**

4. Consultant / Facility Provider:

Name: (Last, First, MI) | **Specialty:**

Institution / Group Name: | **Provider ID:** | **Provider ID #: 2 (If Required)**

Address: (Street #, City, State, Zip)

Phone Number: | **Facsimile / Data Number:**

5. Referral Information:

Reason for Referral:

Brief History, Diagnosis and Test Results:

6. Service Desired: Provide Care as indicated:

__ Initial Consultation Only
__ Diagnostic Test: (specify) _____
__ Consultation With Specific Procedures: (specify)
_____
__ Early, Periodic Screening, Diagnosis & Treatment
__ Standing Referral
__ Specific Treatment: _____
__ Global OB Care & Delivery
__ Other: (explain) _____

Number of visits:
(If blank, 1 visit is assumed)

Authorization #: (If Required)

Signature: (Individual Completing This Form)

7. Place of Service:

__ Office
__ Outpatient Medical/Surgical Center*
__ Radiology __ Laboratory
__ Inpatient Hospital* _____
__ Extended Care Facility* _____
__ Other: (explain) _____
(Specific Facility Must be Named)

Referral is Valid Until: (Date)
(See Carrier Instructions)

Authorizing Signature: (If Required)

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan / carrier. *This form may not be use electronically.*