PLEASE PRINT

OUTPATIENT REFERRAL FORM

Call 866-390-0933
OUT OF NETWORK REFERRALS REQUIRE PRE AUTHORIZATION
A Referral does not guarantee payment.
Specialty care must be coordinated by a participating PCP.

1) MEMBER DEMOGRAPHICS

Name: ______________________________

I.D. Number: ______________________________

D O B: ______________________________

Out-of-Network Referrals must be pre-authorized.

2) REFERRED TO:

____
Name of Specialty Care Physician

____
Specialty

Address ______________________________

Telephone ______________________________

3) SERVICES REQUESTED:

- ☐ Opinion/Consultation Visit **Only (One (1) Visit Only)** Contact Primary Care Physician prior to initiating further treatment
- ☐ Second Opinion **(One (1) Visit Only)** Surgery is not to be performed by this provider
- ☐ Consultation and necessary diagnostic studies only **(Not to exceed three (3) visits)**
- ☐ Consultation, necessary diagnostic studies and treatment. Number of visits ________
- ☐ Follow up care. Number of visits ________
- ☐ Mental Health/Substance Abuse Evaluation and Treatment. Number of visits ________
- ☐ Other ______________________________

Referrals are valid six months from date of referral.

4) DIAGNOSIS / REASON FOR REFERRAL ________________ Code ________________

Payment for services is limited to services covered by the Plan and is dependent on the member's eligibility at the time of service. If further diagnostic or therapeutic services are indicated, Plan notification is required. Please direct requests for additional services to the Primary Care Physician indicated below.

Please forward a report of your findings to the Member's Primary Care Physician at the address noted below:

5) PRIMARY CARE PHYSICIAN'S SIGNATURE ______________________________

Date Referred _____ / _____ / _____

Name: ______________________________

Address: ______________________________

To reorder forms, call 800-241-4848.

To obtain a list of participating providers, visit our website at www.usfhp.net or call 800-241-4848.

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