PacificSource
HEALTH PLANS

REFERRAL REQUEST FORM

From:______________________ Date:______________________

Clinic Name:______________________ City:______________________

Telephone #:______________________ Fax #:______________________

PATIENT'S NAME:____
Last First M.I.

Member ID:______________ Group #:______________ D.O.B:______________

Referring PCP:______________________ Specialty:______________________
Last First
City:______________________

Referral To:______________________ Specialty:______________________
Last First
City:______________________

Level of Service:
1. ______ Consultation Only
2. ______ Treatment Only (CPT Code:______________________)
3. ______ Consult / Medical Treatment
4. ______ Consult / Procedure / Surgery

# of Visits:__________ Start Date:______________ Expiration Date:______________

ICD-9 Code **AND** Description:____

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Notes:____

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-- ***For PacificSource Internal Use Only*** --

PacificSource Ref #:______________ On-panel Provider? Y N Participating with PacificSource? Y N

Approved ☐ Denied ☐ Pending ☐ Referral Entity:______________________

Notes: ____

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Authorized Visits #:______________________ (When PacificSource Health Plans is referral entity)

Authorized By / Processed By: ______________________ Date: ______________