

**REFERRAL
AUTHORIZATION
REQUEST
Managed Care Plans**



**Please fax completed
form to: (541) 225 - 3625**

(PCP) PRIMARY CARE PHYSICIAN INFORMATION

Date: _____ Contact person: _____ Phone: _____
Last name: _____ First name: _____

PATIENT INFORMATION

Last name: _____ First name: _____
Date of birth: _____ Member #: _____
Healthy Kids Connect: Yes No

SPECIALIST INFORMATION

Last name: _____ First name: _____
Specialty: _____ Tax ID: _____
Address: _____ City/State/ZIP: _____
Phone: _____ Fax: _____

REFERRAL INFORMATION

Level of service (scope):

(1) Consultation Only (3) Consult/Medical Treatment (4) Consult/Treatment/Surgery

Requested number of visits: _____ Start date: _____ End date: _____

Primary ICD-9 Code and description: _____

Secondary ICD-9 Code and description: _____

Requesting additional visits on referral already in place? Yes No

If yes, please note all dates used: _____

Other notes: _____