



SANTÉ COMMUNITY PHYSICIANS

MEDI-CAL MANAGED CARE

REFERRAL FORM

Phone: (559) 228-4488

P.O. Box 45021, Fresno, CA 93718

(Direct Physician to Physician contact is needed prior to scheduling)		Urgency of Referral		<input type="checkbox"/> Priority	<input type="checkbox"/> Routine
Health Plan		<input type="checkbox"/> Anthem Blue Cross		<input type="checkbox"/> Health Net	
PATIENT INFORMATION					
PATIENT NAME		Gender <input type="checkbox"/> M <input type="checkbox"/> F	D.O.B.	I.D. # (Include SS# if different)	INS. CARD EFF. DATE
ADDRESS		CITY	STATE	ZIP	PATIENT DAYTIME PHONE #
OTHER INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO Name of Other Carrier:		ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	MVA <input type="checkbox"/> YES <input type="checkbox"/> NO	JOB RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF INJURY
WORKERS COMP CARRIER		WORKERS COMP ADDRESS		WORKERS COMP PHONE #	
REFERRING PRIMARY CARE PHYSICIAN INFORMATION					
PCP OF RECORD _____			SIGNATURE _____		
PCP ON CALL _____			_____		
CONTACT PERSON		PHONE #		FAX #	
REFERRED TO (SPECIALIST) INFORMATION					
■ NO REFERRAL FORM NEEDED FOR LAB, X-RAY, PHYSICAL THERAPY ■ USE PRIOR AUTHORIZATION FORM FOR OUT-OF-PLAN REFERRALS & SERVICES REQUIRING PRIOR AUTHORIZATION					
SPECIALIST NAME (Print)		PHONE #		ADDRESS	
CHECK (✓) IF REFERRING TO: <input type="checkbox"/> Diabetes Care Center <input type="checkbox"/> Cardiac Rehab <input type="checkbox"/> Pulmonary Rehab <input type="checkbox"/> Dietary Consultation					
REFERRAL INFORMATION					
DIAGNOSIS				ICD-10 CODE	
DATE OF REQUEST		# OF VISITS (Valid for 180 days)		<input type="checkbox"/> CONSULTATION ONLY <input type="checkbox"/> CONSULTATION AND TREATMENT <input type="checkbox"/> REFERRAL FOR TREATMENT	
SEE REFERRAL GUIDE AND ATTACH APPROPRIATE MEDICAL RECORDS TO EXPEDITE REFERRAL					
<input type="checkbox"/> PROGRESS NOTES ATTACHED		<input type="checkbox"/> CONSULTATION NOTES ATTACHED		<input type="checkbox"/> NOTES WITH SPECIFIC FINDINGS ATTACHED	
<input type="checkbox"/> EKG ATTACHED		<input type="checkbox"/> LAB REPORT ATTACHED		<input type="checkbox"/> X-RAY REPORT ATTACHED	
<input type="checkbox"/> IMAGING STUDY REPORT ATTACHED		<input type="checkbox"/> MEDICATION LIST ATTACHED		<input type="checkbox"/> CARDIAC RELATED STUDIES ATTACHED	
<input type="checkbox"/> IMMUNIZATION RECORD ATTACHED		<input type="checkbox"/> Other _____			

Mail copy to Santé at P.O. Box 45021, Fresno, CA 93718

Mail or fax a copy to Specialist

Place a copy in patients chart

- THIS REFERRAL DOES NOT GUARANTEE PAYMENT OF NON-COVERED SERVICES
- THIS REFERRAL DOES NOT GUARANTEE PAYMENT IF PATIENT IS NOT ELIGIBLE