IHP

Integrated Health Partners

Referral Request Form

Phone #: (269) 425-7110
Fax #: (269) 425-7162

Date _____/_____/_____

PATIENT INFORMATION

BCN_____ UHC Community Plan_____ Meridian Health Plan_____

BCN Group # ☐ **00282189** ☐ **00281419** ☐ **00280456** ☐ **00283318** ☐ **00284866** ☐ **N/A**

Patient Name:_____ Phone: _____

Patient's Contract #:_____ DOB: _____/_____/_____

PROVIDER/SPECIALTY

Referred BY Provider: _____ Provider NPI #:_____

Referred TO Provider: _____ Provider NPI #:_____

Facility/Hospital: _____ Facility NPI #:_____

REQUESTED SERVICES INFORMATION

Services Start Date ____/____/_____ Services End Date: ____/____/_____ # of Visits:_____

TYPE OF SERVICE (Circle One): OV OP OPS DME MH ER PT/OT/SPEECH OB IP
Level of Care (Check One): [ ] Consult Only [ ] Consult w/Diagnostics [ ] Global

ICD-10 Code 1):_____2):_____3):_____4):_____
Diagnosis _____

CPT Code 1):_____2): _____3):_____4):_____
Procedure _____

Office Contact:_____ Phone #:_____ Fax #:_____

IHP Office Use Only

#	No Authorization Required	Approved	Denied	Redirected to In-Network Provider	Disagree with Redirection
	☐	☐	☐	☐	☐

This referral authorization is valid only for the provider and services listed. An additional referral authorization is required if further services other than those indicated above are necessary. Only those health services covered by the policy/plan of the member/covered person/eligible person at the time of services are eligible for reimbursement, even if ordered by a physician.

Referral Type: ☐ Clinical Review ☐ Routine Referral

Classification: ☐ Info Not Received ☐ Contract Termed ☐ Benefit Limitation ☐ No PCP Referral ☐ Benefit Exclusion ☐ Medical Necessity

☐ Preservice Urgent (72 hours) ☐ Preservice Non-Urgent (15 days) ☐ Post Service (30 days)

Met decision time frame: ☐ Yes ☐ No

Received Date: _____ Completed: _____ Clinical Documentation Requested Date: _____ Clinical Documentation Received Date: _____

IHP Medical Director Review Date: _____ Plan Medical Director Review Date: _____

Decision Made: _____ Date Provider Notified: _____ Date Patient notified: _____

Form Revised: January 18, 2018