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➤ IMPORTANT NOTICE - REFERRAL AUTHORIZATION SUBMISSIONS ◀

**↪ REQUIRED MEDICAL RECORDS FOR REFERRAL REQUESTS ↪
↪ NEW REFERRAL REQUEST FORM ↪**

⇒ **Web Portal**

Preferred IPA has a web authorization portal for submission and tracking of referral authorizations. Call 818-265-0800 and ask for Provider Relations for more information.

⇒ **Required Medical Records For Referral Requests**

Health plans are auditing referral requests from provider offices for compliance with medical record submission. Office visit notes and lab or diagnostic results pertaining to each request are required to process every referral. Incomplete referrals will be returned to the requesting provider for immediate action to provide necessary clinical documentation.

Provide clinical records as follows:

- Web submissions-attach pertinent records on the web portal by uploading attachments.
- Fax submissions-indicate the patient name, date of birth, and the authorization tracking number on the records. Fax all pages to 800-874-2093.

LAST TWO OFFICE VISIT NOTES and LAB/DIAGNOSTIC RESULTS PERTAINING TO EACH REQUEST ARE REQUIRED TO PROCESS ALL REFERRAL REQUESTS

⇒ **New Referral Form (Fax Submission Only)**

Attached please find the revised Referral Authorization form for hard copy referral requests.

Complete all fields on the form to ensure timely processing of referral requests. The form has been revised to remove the health plan selection boxes. We have moved the health plan field next to the member number in the member information box as shown here:

Patient Name	LAST	FIRST	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>	DOB	AGE
Address		City		Zip	Phone	
Member Number & Health Plan		Language Required (Interpreter Services Available)				

If you have any questions, please contact Provider Relations: (818) 265-0800



REFERRAL / AUTHORIZATION REQUEST

Fax authorization request to: (800) 874-2093
Phone (800) 874-2091

DATE SUBMITTED:

LAST TWO OFFICE VISIT NOTES and LAB/DIAGNOSTIC RESULTS PERTAINING TO THIS REQUEST ARE REQUIRED TO PROCESS THIS REFERRAL

MARK HERE FOR TYPE OF REQUEST: URGENT ROUTINE RETROACTIVE INPATIENT

Patient Name	LAST	FIRST	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>	DOB	AGE
Address		City		Zip	Phone	
Member Number & Health Plan			Language Required (Interpreter Services Available)			

PATIENT REFERRED TO:	Address:
Specialty:	PHONE#: _____ FAX #: _____

REFERRING PHYSICIAN:	Referring Physician Address
Referring Phone:	Referring Signature (REQUIRED)
Referring Fax:	

Diagnosis Codes (ICD10):	Diagnosis Description:
ICD10 Code 1:	
ICD10 Code 2:	

IMPORTANT NOTICE REGARDING QUEST and LAB CORP - LABS MUST BE SENT TO THE ASSIGNED CONTRACTED LAB FOR THE MEMBER'S PCP. PLEASE CALL 818-265-0800 x200 TO VERIFY CONTRACTED LABORATORY PROVIDER.

CPT CODES		CPT CODES	
<input type="checkbox"/> Consultation w/ Dx & Report	99243 _____	<input type="checkbox"/> Out-Patient Procedure	_____
<input type="checkbox"/> Follow-up Visit (_____/visits)	99213 _____	<input type="checkbox"/> DME / Prosthetics	_____
<input type="checkbox"/> Ultrasounds	_____	<input type="checkbox"/> Home Health Care	_____
<input type="checkbox"/> Routine Pregnancy Care	LMP:____ EDC:_____	<input type="checkbox"/> CT/MRI	_____
<input type="checkbox"/> Family Planning	_____	<input type="checkbox"/> Physical Therapy Visit	_____
<input type="checkbox"/> Hospital In-Patient Care	_____	<input type="checkbox"/> Other	_____

Reason for referral – ATTACH PERTINENT PROGRESS NOTES, CONSULT NOTES, LABORATORY/ DIAGNOSTIC RESULTS

What has been tried? For how long? With what results? How will this affect treatment? Please explain.

<p>AUTHORIZATION OF REQUESTED SERVICES AND PAYMENT OF CLAIMS ARE BASED ON VERIFICATION OF CONTINUED ELIGIBILITY. SPECIALIST: PLEASE PROVIDE CONSULTATION REPORT AND FOLLOW UP NOTES TO PCP</p> <p>**SPECIALISTS MAY REQUEST FOLLOW UP VISITS OR PROCEDURES DIRECTLY**</p>

Practitioners, members and the public may request a copy of the criteria used to make an authorization decision by calling the IPA. If you would like to discuss a denial decision, you may contact the Medical Director at 818-265-0800 x249.

<input type="checkbox"/> Approved	<input type="checkbox"/> Pend	<input type="checkbox"/> Denied	<input type="checkbox"/> Modified	Review Date _____
Notes:				