

# INJECTABLE REFERRAL FORM

Noble AMA Select IPA Medical Group, Inc

Fax: (760) 631-1619

Phone: (877) 207-7600

APPLICABLE COPAY	AUTHORIZATION NUMBER

Date of Referral Request: \_\_\_\_/\_\_\_\_/\_\_\_\_  Emergent  Routine  Urgent  Retro

Patient name (First, MI, Last): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: \_\_\_\_\_ Patient ID# \_\_\_\_\_

Health Plan: \_\_\_\_\_ Patient SS#: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Allergies: \_\_\_\_\_

**Referred From:** MD Office Contact Name: \_\_\_\_\_

Provider Name: \_\_\_\_\_

PCP/Specialty: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**SIGNATURE OF REFERRING PROVIDER:** \_\_\_\_\_

(MANDATORY - WILL NOT BE PROCESSED WITHOUT SIGNATURE) \_\_\_\_\_

\_\_\_\_\_

**Referred To:** Vendor: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Drug Administered By:  MD  Home Health  PT

Deliver To: \_\_\_\_\_

Address: \_\_\_\_\_

City, ST, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

<b>*Diagnosis Code:</b>	<b>ICD-9</b>
_____	_____
_____	_____
_____	_____

<b>Drug Name:</b>	_____
J Code:	_____
Dosage:	_____
Frequency:	_____
Route (SQ/IM):	_____
Duration of Treatment:	_____
_____	_____

<b>Drug Name:</b>	_____
J Code:	_____
Dosage:	_____
Frequency:	_____
Route (SQ/IM):	_____
Duration of Treatment:	_____
_____	_____

<b>Drug Name:</b>	_____
J Code:	_____
Dosage:	_____
Frequency:	_____
Route (SQ/IM):	_____
Duration of Treatment:	_____
_____	_____

Reason for Referral:
_____
_____
_____

<b>UM STAFF ONLY</b>	<b>Benefits Verified By:</b> _____
<input type="checkbox"/> Authorize Date: _____	<input type="checkbox"/> Pending Date: _____ <input type="checkbox"/> Modified Date: _____
<input type="checkbox"/> Denied Date: _____	<input type="checkbox"/> Not a covered benefit
<b>Comments:</b> _____	_____
_____	_____
<b>UM Signature:</b> _____	<b>Date:</b> _____
<b>Date PCP Notified:</b> _____	<input type="checkbox"/> Please notify member today of referral status.

Certification does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions. This certificate is good for sixty (60) days from approval date.

**\*This section must be reviewed by physician prior to submission.**