**CHOC Health Alliance Referral Form**

**This form should NOT take the place of a Prior Authorization (PA) request, nor should it be used to submit a PA.**

For proper payment of services, the *recipient* of this referral *must* verify Member eligibility on the date of service.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of Request:**  Date of Request: | | | | | |
| **PATIENT INFORMATION** | | | | | |
| **Patient Name:** | | **Patient DOB:** | | | **ID Number:** |
| **Patient Address:**  **Parent/ Guardian Name:** | | **Guardian Name:** | | | **Parent/Guardian Phone:** |
| **REQUESTING PROVIDER INFORMATION**  **(provider who is initiating the referral)** | | | | | |
| **Name of Person Completing Referral Form:** | | | | | |
| **Name of Referring Physician:** | | | | | |
| **Clinic/Office Address:** | | | | | |
| **Telephone Number:** | | | **Fax Number:** | | |
| **REFERRAL TO SPECIALIST INFORMATION**  **(name of provider you would like the patient to see)** | | | | | |
| **Name of Recipient Provider:** | | | | | |
| **Clinic/Office Address:** | | | | | |
| **Telephone Number:** | | | **Fax Number:** | | |
| **REFERRAL SERVICE**  **(Description of the service that is being requested by the referring provider)** | | | | | |
| * This Referral Form is for Evaluation & Management (E&M) Consultation services to an in-network Specialist with CHA * All Podiatry services require PA (including consults/E&M codes); please submit via online EZNET System or PA Form * Ophthalmology services require PA (excluding E&M codes and codes 92015, 92060, and 92250); please submit via online EZNET System or with PA Form * Office based procedures (diagnostic testing, minor surgical procedures, etc. not noted in the CHOC Health Alliance Quick Reference Guide) require PA; please submit via online EZNET System or with PA Form * Please refer to the CHA Quick Reference Guide for guidance on services/codes that do not require a Prior Auth | | | | | |
| **□ Consultation** | **□ Evaluation and Treatment** | | | **□ Follow-Up Visit(s):** | |
| **Diagnosis(s):** | | | | | |
| **Clinical Summary Remarks: (Please attach ALL pertinent documentation to support the reason for visit.)** | | | | | |

* ***A copy of this referral should be filed in the medical record of both the originating physician and the consulting physician.***
* ***This referral does not guarantee payment of non-covered services or if a patient is not eligible.***