PIEDMONT COMMUNITY HEALTH PLAN
Community Partners for Quality Healthcare

Authorization/Referral Request

Fax all documents to (434) 947-4465 **All requests are processed within an average of 48hrs.**

NOTE: For all PCHP plans, DO NOT MARK THIS REQUEST AS URGENT/EXPEDITED UNLESS the member's provider feels that, "…applying the standard time for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function." (CMS Medicare Managed Care Manual, Chapter 13, Section 50.1)

SECTION A. MEMBER INFORMATION			
Member Name:			
Member Number:		Member DOB:	

SECTION B. SENDING (REFERRING) PRACTICE INFORMATION			
Practice Name:			
Physician:			
Practice Contact Name:			
Contact Phone Number:			
Contact Fax Number:			
Request For *(check all that apply)* :	☐ OFFICE VISIT	☐ PROCEDURE	☐ OTHER
Patient to Receive Care As *(check all that apply)* :	☐ INPATIENT	☐ OUTPATIENT	

SECTION C. REFERRED TO/REQUESTED PROCEDURE/SERVICE INFORMATION *(Mark "N/A" if not applicable)*			
Practice/Facility Name Referred To:			
Practice/Facility NPI:		Practice/Facility Tax ID:	
Individual Physician Referred To:		Physician NPI:	
Specialist Type:			
Planned Dates of Procedure/Service:	Start Date:	End Date:	
Requested Duration: *(no longer than 1 year)*		*(choose one)* ☐ Days ☐ Visits	
Related CPT Codes and Diagnosis Codes			
Supporting Diagnosis Description			
Additional Information			

Clinical Notes/Information Attached: ◯ Y ◯ N Number of Pages:_____

Fax this coversheet and the following documentation as applicable:
(1) Office notes detailing the need for the request;
(2) All pertinent lab and imaging information (e.g. x-ray, ultrasound, etc.).