Authorization/Referral Request

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

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.)

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)

☐ **Urgent** Ordered by Physician ☐ **Date of Service Same/Next Day** ☐ **Please Review** Standard

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

SECTION B. SENDING (REFERRING) PRACTICE INFORMATION			
Practice Name:			
Physician:			
Practice Contact Name:			
Practice Phone and Extension:		Practice Fax:	
Request For *(check all that apply)* :	◯ OFFICE VISIT	◯ PROCEDURE	◯ OTHER
Patient to Receive Care As *(check all that apply)* :	◯ INPATIENT	◯ OUTPATIENT	
Check if member is **likely to have lab tests** as part of a visit to an out of network provider and/or by an out of network lab.			

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:			
Phone and Extension:		Fax:	
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:_____

Name of Person Sending Request	
Phone Number and Extension	
Fax Number	

Please copy and reproduce this form as needed for future use with PCHP.