# SPECIALIST REFERRAL AND PRE-NOTIFICATION FORM

**Fax request to 1-800-973-2321**

If you would like to submit notifications online, you can visit **www.CHC-Care.com**

## Patient Information:

Patient name:_____ Patient date of birth:_____

Employer name: _____ Cardholder ID number:_____

## Requesting Physician Information:

Physician name: _____ Physician phone: _____

Physician address: _____

Physician fax: _____ Attention to:_____

Person completing request: _____ Request date: _____

## Specialist Referral Request:

Specialist name:_____ Specialist phone:_____

*Last* *First*

Specialist fax: _____ Requested effective date:_____

ICD9 Code or reason for referral: _____

Scope of referral:

- ☐ Unlimited visits for one year
- ☐ Other timeframe *(Please Specify)*:_____

## Pre-Notification Request:

Please submit any historical/clinical information that supports the need for the requested service(s)

Provider/Facility name: _____

Provider/Facility phone: _____ Provider/Facility fax:_____

ICD9 Code or reason for procedure: _____

CPT/HCPC Code(s)*: _____

Place of service: ☐ In-patient ☐ Out-patient ☐ Clinic/Office ☐ DME

Projected date of procedure:_____

**Required. Failure to provide code(s) may delay response.*

CARE COORDINATORS
BY QUANTUM HEALTH

*Revised 1/6/15*