

Referral Form

Incomplete forms will be faxed back.

FAX: (877) 795-2746 Phone: (800) 678-9133

MEMBER NAME – LAST, FIRST, MIDDLE INITIAL		Is this a member request? <input type="checkbox"/>	DATE OF BIRTH	HEALTH PLAN I.D. NO.
		Yes No		
MEMBER ADDRESS – STREET, CITY, ZIP CODE			PATIENT PHONE NO.	
REQUESTING PROVIDER <input type="checkbox"/> PCP <input type="checkbox"/> SPECIALIST		PHONE NO. ()	FAX NO. (MUST HAVE FOR FAX BACK) ()	
		DATE PREPARED	PREPARED BY	ELIG CHECKED Yes <input type="checkbox"/> No <input type="checkbox"/>

Routine/Standard: Routine requests will not exceed five (5) business days from receipt of all necessary information.

Urgent Request: Urgent requests will not exceed 72 hours.

REQUESTING PROVIDER NAME		REQUESTING PROVIDER EMAIL	REFERRAL ISSUE DATE:
ADDRESS – STREET, CITY, ZIP CODE		PHONE NO. ()	FAX NO. ()
Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/>	FACILITY NAME		INPATIENT GOAL LENGTH OF STAY
DIAGNOSIS	ICD CODE	PROCEDURES/EQUIPMENT	CPT CODE

REASON FOR REFERRAL (PLEASE INCLUDE ALL PERTINENT DOCUMENTATION)

Payment for services is dependent upon the Patient's eligibility at the time services are rendered. Provider to call Health Plan for benefits and eligibility each visit.

IMPORTANT <input type="checkbox"/>	* FAX completed referral forms to (877) 795-2746.
	* Mail to ASH, 10221 Wateridge Circle, San Diego, CA 92121
	* Please call ASH at (800)-678-9133 for authorization questions.

COMMENTS:

REFERRAL EFFECTIVE DATE:

HIPAA Notice: The information contained in this form may contain confidential and legally privileged information. It is only for the use of the individual or entity named above. If the recipient of this form is not the recipient addressed on the form, you are hereby notified that any dissemination, distribution, or copying of the attached document(s) is strictly prohibited. If you have received this in error, please immediately notify the sender by telephone and return the form to the sender. 3 / 3 1 / 1 4