

Referral Request Form Instructions:

The Referral Request Form is available on Unity's website at www.unityhealth.com.

Please note: This is a referral **request**. Providers and patients will receive a printed copy of the referral form as confirmation of authorization. If the request is not authorized, a letter with the reason for the non-authorization will be sent to the provider and patient.

Field Numbers	Instructions
(1) Medical Management Contact Information	Address, phone #'s and fax #.
(2) Date Requested	Fill in the date that the <u>form is being completed</u> by clinic/staff.
(3) Patient's Name	Fill in the patient's full name as it appears on the insurance card.
(4) Date of Birth (DOB)	Fill in the patient's DOB.
(5) Member Number	Fill in members's number as shown on Unity Health Insurance ID card. This 11 digit number starts with 713 and ends with 2 digits which identifies them as a subscriber (00) or dependent (01, 02, etc.). (Example: 713XXXXXX-XX)
(6) Date of Service	Fill in the date that service is to be provided.
(7) Authorizing/Referred From:	Fill in the COMPLETE name and mailing address of the PCP or other provider who is requesting service. Check box if PCP is making the referral at the patient's request. If possible, fill in the date that the patient was last seen by PCP.
(8) Referred from Clinic Contact	Fill in the name of the Clinic Contact that can answer inquiries and/or receive information about the referral. Phone and fax number of the Clinic Contact. Site/Location: if there are multiple locations.
(9) Referred To:	Fill in the COMPLETE name and mailing address of the Specialist/Provider.

Field Numbers	Instructions
(10) Referred to Provider Contact	Fill in the name of the Provider Contact at the Specialist/Provider's office that can answer inquiries and/or receive information about the referral. Phone and fax number of the Provider Contact. Site/Location: where services are to be provided.
(11) Services Requested	Check appropriate box for service(s) being requested.
(11) Primary Diagnosis Code	Primary diagnosis code with ICD9 number/code. Written description of primary diagnosis.
(11) Procedure Code(s)	Procedure code(s) by CPT4 code: eg 58150. Written description of procedure. (Example: abdominal hyst) HCPCS code if requesting DME item.
(11) Applicable diagnostic testing performed	List any testing that was performed. (Example: X-Ray or MRI)
(11) Prior Authorization: Surgery/Inpatient/Outpatient	Check Prior Authorization box if the requesting service(s) is on the prior authorization list only . If surgery is requested, please indicate whether inpatient or outpatient status. Any service(s) on the prior authorization list will require medical information submitted with the initial referral, unless the clinic has HealthLink access.
(11) Coordination of Benefits	Please check appropriate box for Worker's Compensation, Subro/MVA or other Insurance, if applicable.
(11) Please send Consult Notes Back to Referring Physician	Check this box when requesting consult notes go back to the referring PCP.
(12) Comments	Additional comments to explain services you are requesting. For example: -Pre-certification information -Medical necessity for services -Number of visits requested
(13) Unity/UWMF Administrative Information	For Medical Management use only.