DIRECT REFERRAL FORM

☐ **AltaMed Health Services** ☐ **Omnicare Medical Group** ☐ **LaSalle Medical Associates** ☐ **Family Choice Medical Group**

PATIENT INSTRUCTIONS

1. **Make an Appointment:** Call the specialist or provider listed below to schedule your appointment.

2. **Bring This Form:** Take this form with you to your appointment and give it to the office staff. This form is called a Direct Referral form because the services listed below do not need prior approval.

3. **Bring Medical Records:** Bring all your medical records to the appointment, including test results, x-rays, ultrasound reports, or MRIs.

PATIENT INFORMATION

Last Name: **First Name:** **DOB:**

Address: **City:** **State:** **Zip:**

Phone: **Health Plan:** **Health Plan ID:**

REFERRING PROVIDER INFORMATION

Name: **Phone:** **Fax:**

Address: **Date Seen:**

REFERRED TO SPECIALIST/ANCILLARY PROVIDER INFORMATION

Name: **Phone:** **Fax:**

Address: **Specialty:**

RENDERING PROVIDER INSTRUCTIONS

1. **Verify Eligibility:** Authorization is based on the patient's eligibility at the time of service. Please verify the patient's eligibility before providing services.
2. **Perform Listed Services:** Only perform the services listed on the form. If additional care is needed, contact the UM Department at 323-417-7741 or fax the request with relevant medical records, reports, and test results to 323-720-5608.
3. **Submit Forms:** Attach a copy of this form to the CMS 1500 form and send it to: P.O. Box 7280, Los Angeles, CA 90022-7280.
4. **Interpreter Services:** Free interpreter services are available for members with limited English proficiency or hearing impairments. Call the Member Services Department of the member's health plan for assistance.
5. **Return Reports:** Please return the consult report and any other pertinent information to the requesting provider and/or PCP.

Primary Care Provider & Fax *(If different than Requesting Provider)*: _____

Requesting Provider Signature: _____

On the following page, please indicate the services needed based on the Preventive Services Information Guide located on the Connect Provider Portal which provides a full listing of services that are considered preventive and/or are exempt from prior authorization and therefore may utilize the Direct Referral Form.

Altura Management Services

DIRECT REFERRAL FORM

Please indicate the services needed based on the Preventive Services Information Guide located on the Connect Provider Portal for a full listing of services that are considered preventive and/or are exempt from prior authorization and therefore may utilize the Direct Referral Form:

SERVICES NEEDED (SELECT ONE & ADD CPT CODE)	
☐ **Family Planning Services**	**CPT Code(s):**
☐ **Basic Prenatal Care**	**CPT Code(s):**
☐ **Direct Access to Women's Services**	**CPT Code(s):**
☐ **Preventive Services**	**CPT Code(s):**
☐ **Behavioral Health**	**CPT Code(s):**
☐ **Dietician**	**CPT Code(s):**
☐ **Neurology – Sleep Study (Medi-Cal ONLY)** Applicable if the following are documented: 1. Suspected sleep apnea, or severe sleep disturbances 2. A sleep center study should be conducted if a member is suspected of having sleep apnea despite a low probability. Additionally, a sleep center is appropriate if there are issues with conducting a home study, mental health concerns, other medical conditions, or if the patient is a child	**CPT Code(s): 95810 or 95811**

REASON FOR REQUEST

Important Notice: *Please be aware that sensitive services, family planning, preventive services, and other services exempt from prior authorization have specific age and gender requirements. For detailed information, kindly refer to the Preventive Services Information Guide.*