carecentrix

REFERRAL FORM

Please note, failure to complete all of the fields on this form may result in delay of patient care.

PATIENT DEMOGRAPHICS

DATE REFERRAL SENT TO CARECENTRIX			
LAST NAME	FIRST NAME		DATE OF BIRTH
STREET ADDRESS (WHERE SERVICES RECEIVED)(PO BOX NOT APPLICABLE)	CITY	STATE	ZIP
PHONE # (WITH AREA CODE)	ALTERNATE PHONE #		GENDER

REFFERAL/FACILITY INFORMATION

	ADMISSION DATE	DISCHARGE DATE	FAX #
CONTACT NAME/FACILITY NAME	PHONE # (WITH AREA CODE)		PLACE OF SERVICE (*Required for Florida Blue Sleep Diagnostics*)
AFTER HOURS CONTACT	AFTER HOURS CONTACT #		☐ 11 – office, clinic ☐ 12 – home sleep test ☐ 19 – off – campus outpatient hospital ☐ 22 – hospital based lab ☐ 49 – independent clinic
CONTRACTED WITH HEALTH PLAN ☐ Yes ☐ No			

INSURANCE INFORMATION

	SUBSCRIBER ID #		
INSURANCE NAME	GROUP#	OTHER INSURANCE	Reminder: Auth Place of Service MUST match claim Place of Service to prevent claims denial issue.
SUBSCRIBER'S LAST NAME	SUBSCRIBER'S FIRST NAME	SUBSCRIBER'S DATE OF BIRTH	PATIENT'S RELATIONSHIP TO SUBSCRIBER

CLINICAL INFORMATION

ATTACH ADDITIONAL CLINICAL INFORMATION TO SUPPORT REQUEST:
- MD SIGNED ORDER/DISCHARGE ORDERS IF COMING FROM A FACILITY
- HISTORY & PHYSICAL AND DISCHARGE SUMMARY
- MD SIGNED LOMN – IF THIS IS A REQUIREMENT PER THE MEDICAL COVERAGE GUIDELINES
- FOR PROVIDER REFERRALS – MD SIGNED PLAN OF CARE / HCFA 485
- NURSING OR THERAPY EVALUATION AND VISIT NOTES FOR EACH REQUESTED DISCIPLINE
- WOUND ASSESSMENT/SPECIFIC WOUND CARE ORDERS/LIST OF WOUND CARE SUPPLIES
- MOST RECENT SLEEP TEST

PRIMARY DIAGNOSIS TO SUPPORT REQUESTED SERVICE(S)	OTHER SUPPORTING DIAGNOSIS	RECENT APPLICABLE PROCEDURE/SURGERY AND DATE

HOMEBOUND STATUS (PLEASE CIRCLE THE SELECTION THAT BEST DESCRIBES PATIENT SITUATION)

- PAIN WITH AMBULATION OF SHORT DISTANCES
- BED BOUND
- REFUSES TO LEAVE HOME DUE TO PSYCHIATRIC ILLNESS
- SOB WITHOUT MINIMAL EXERTION
- WHEELCHAIR BOUND AND UNABLE TO SIT FOR EXTENDED PERIODS OF TIME
- UNABLE TO AMBULATE MORE THAN 100 FT WITHOUT RESTING
- UNABL TO LEAVE HOME BECAUSE UNABLE TO NEGOTIATE STAIRS
- INFECTION; IMMUNE COMPROMISED DUE TO: _____

PLEASE EXPLAIN: _____

SERVICE REQUESTS

				ABLE AND WILLING CAREGIVER (NAME AND PHONE NUMBER)	
ALLERGIES				HEIGHT WEIGHT *(REQUIRED FOR INFUSION THERAPY AND APPLICABLE HME)*	
FOR INFUSION ONLY:			TYPE OF ACCESS	NEXT DOSE DUE DATE/TIME	IS THIS A FIRST TIME DOSE? ☐ Yes ☐ No
O2 SATURATION LEVEL	DURATION	LITER FLOW	ROUTE-IE: MASK, NASAL	DATE OF ORDER	START DATE (IF DIFFERENT THAN DATE OF ORDER)
DETAILED DESCRIPTION OF ITEMS NEEDED FOR O2:					REQ SOC DATE RANGE
HOMECARE ORDERS (PLEASE SPECIFY)					REQ SOC DATE RANGE
BREAST FEEDING REQUESTS – WHAT IS THE PREFERRED BRAND?			FL BLUE – HAS THE PATIENT REGISTERED FOR DELIVERY OR DELIVERED IN THE LAST 9 MONTHS?		DELIVERY DATE
DELIVERY INFORMATION (IF DIFFERENT FROM ADDRESS ABOVE)					

PHYSICIAN INFORMATION

	PRIMARY CARE PHYSICIAN NAME AND PHONE NUMBER
ORDERING PHYSICIAN'S FIRST AND LAST NAME/TAX ID/NPI	FACILITY CONTACT INFORMATION:
ORDERING PHYSICIAN PHONE #	

ADDITIONAL CLINICAL INFORMATION