US FAMILY HEALTH PLAN
A TRICARE Prime® Option

OUTPATIENT REFERRAL FORM

PCP SECTION

1. Complete the **MEMBER DEMOGRAPHICS** section below with Patient Name, USFHP ID Number, and Date of Birth.
2. Select **PRIORITY OF VISIT REQUESTED.**
3. Select the **REFERRAL TYPE** for the specialty the BENEFICIARY is being referred. If you don't see the specialty listed, please select OTHER, and the write in the Specialty. **NOTE:** At USFHP, it is the member's responsibility to identify an in-network specialist.
4. Complete **REASON FOR REFERRAL.**
5. **PRINT NAME, SIGN, DATE**, and provide **Telephone, FAX** and **Office Address** for the Referring Physician
6. Please provide a copy to the Beneficiary, and keep one copy for your records.

NOTE: This form is for in-network referrals only. OUT OF NETWORK REFERRAL MUST BE AUTHORIZED BY THE USFHP UTILIZATION DEPARTMENT AT (866) 560-9069.

MEMBER DEMOGRAPHICS

_____
Patient Name

_____
ID Number

_____
Date of Birth

PRIORTY OF VISIT REQUESTED (select one):

- ☐ STAT (within 1-2 days)
- ☐ URGENT (within 7 days)
- ☐ NON-URGENT ROUTINE (within 4 weeks)

REFERRAL TYPE (select one):

- ☐ Allergy & Immunology
- ☐ Cardiology
- ☐ Interventional Cardiology
- ☐ Nuclear Cardiology
- ☐ Dermatology
- ☐ Endocrinology
- ☐ Gastroenterology
- ☐ General Surgery
- ☐ Hematology & Oncology
- ☐ Infectious Disease
- ☐ Nephrology
- ☐ Neurology
- ☐ Ophthalmology
- ☐ Orthopedic Surgery
- ☐ Otolaryngology
- ☐ Pulmonology
- ☐ Sports Medicine
- ☐ Pain Medicine
- ☐ Rheumatology
- ☐ Urology
- ☐ Vascular Disease
- ☐ **Other** (please list):

_____
_____

Reason for Referral: _____

_____

_____

Physician: _____ Signature: _____

Date: __ __/__ __/ __ __ __ __ Telephone: ( ) _____ Fax: ( ) _____

Office Address: _____

MEMBER SECTION

To obtain a list of participating providers, visit our website at www.usfhp.net or call (800) 241–4848

CONSULTANTS SECTION

THIS FORM IS FOR INFORMATION PURPOSES ONLY, IT IS NOT NECESSARY FOR PAYMENT. PLEASE RETAIN A COPY FOR THE PATIENT FILE. REPORT OF YOUR FINDINGS IS NECESSARY FOR CONTINUITY OF PATIENT CARE. PLEASE FAX OR MAIL YOUR FINDINGS USING A FORMAL LETTER, NOTE, OR COPY OF YOUR VISIT NOTE, TO REFERRING PHYSICIAN AT ADDRESS ABOVE WITHIN 10 DAYS, OR SOONER DEPENDING ON THE URGENCY.

THIS FORM IS NOT SUFFICIENT FOR AN OUT OF NETWORK REFERRAL; IT MUST BE ACCOMPANIED BY AN AUTHORIZATION FROM THE USFHP UTILIZATION REVIEW DEPARTMENT.