USFHP OUTPATIENT REFERRAL FORM

OUT OF NETWORK REFERRAL MUST ALSO BE AUTHORIZED BY THE USFHP UTILIZATION DEPARTMENT AT 866.390.0933

MEMBER DEMOGRAPHICS

PATIENT NAME: _____

ID NUMBER: _____

D O B: _____

REFERRED TO:

PHYSICIAN: _____

SPECIALTY: _____

ADDRESS: _____

_____

TELEPHONE: _____

PRIORTY OF VISIT REQUESTED:

☐ **STAT (within 1-2 days)**

☐ **URGENT (within 7 days)**

☐ **ROUTINE (within 4 weeks)**

☐ **NON URGENT**

Appointment Date: _____

Appointment Time: _____

IF OUT of NETWORK: AUTHORIZATION NUMBER: _____

REQUESTED SERVICES:

☐ **CONSULTATION (ONE VISIT ONLY)**
☐ **SECOND OPINION (ONE VISIT ONLY)**
☐ **CONSULT AND NECESSARY DIAGNOSTIC TESTING (THREE VISITS)**
☐ **VISITS CONSULT, DIAGNOSTIC TESTING AND FOLLOW UP**
☐ **FOLLOW UP AND DIAGNOSTIC TESTING**
☐ **OTHER**
☐ **CONSULT and _____ FOLLOW-UP VISITS over _____ MONTHS**

REASON FOR REFERRAL: _____

_____

_____

_____

*****ATTENTION CONSULTANTS:**

THIS FORM IS FOR INFORMATION PURPOSES ONLY, IT IS NOT NECESSARY FOR PAYMENT. PLEASE NOTE A 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.

REFERRING PHYSICIAN: _____ **DATE:** _____

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