

New York-Presbyterian Community Health Plan

Referral Form

Check here if services are required within 24hrs

Reference No. _____

Date _____ Fax# 1-866-826-6653***** Phone# 1-800-390-7634

GENERAL INFORMATION

Clinic Name/Referred by Primary Care Physician/Provider _____

Provider ID# _____ Member ID# _____

Patient/Member Name _____ Patient/Member Date of Birth _____

Diagnosis _____

Accident Related? _____ If yes, date and time of accident _____

Does the patient have any special needs?
(Check appropriate boxes)

- Specialized Transportation
 Interpretive Services
 Mobility Impairment
 Cognitive Impairment

- Visual Impairment
 Hearing Impairment
 Other _____
(Please specify)

OUTPATIENT INFORMATION (Requires UM Authorization if for a non-participating provider or greater than 6 visits)

Referred to _____ Provider ID# _____

Specialty _____ Specialist Fax# _____

Type of Service/Procedure _____

(Please include applicable CPT of HCPCS Codes)

Number of Visits Requested _____

Service Start Date _____ Service End Date _____

INPATIENT INFORMATION (Requires UM Authorization)

Admission Date _____ Facility _____

Admitting Physician _____ Provider ID# _____

Attending Physician _____ Provider ID# _____

Type of Procedure(s)/Date(s) _____ Medical Record # _____

Clinical Findings

CONTACT PERSON NAME (Please Print):

Telephone Number:

Fax Number:

_____ () _____ - _____ () _____ - _____

Referral valid for 90 days from Service Start Date