

ADDING A REFERRAL REQUEST

All Searches Patient Last Name: Patient First Name:

All Searches Insurance ID: Date of Birth:

Referrals Only Referral ID: Auth Request Date:

EOBs Only Check Date From: Check Date Thru:

2. Click Add Referral →

3. A patient listing will appear. Be sure to select the correct patient and click Add Referral.

Patient	DOB	Sex	Insurance ID	Carrier	Plan ID	Plan Name
Add Referral Last Name, First Name	DOB	M	Insurance ID	SCFHP0	MC10	SANTA CLARA FAMILY HEALTH PLAN
Add Referral Last Name, First Name	DOB	F	Insurance ID	SCFHP0	MC10	SANTA CLARA FAMILY HEALTH PLAN

4. Complete the required fields for the referral request. Ensure accuracy of your data entry before submitting your request.

Patient: Last Name, First Name

Ins ID Num: Insurance ID # Rel to Ins: City/State/Zip: SAN JOSE CA 95126-2439 DOB: DOB Age: 70 Sex: M

Address: Address PCP: Speciality: INTERNAL MEDICINE Carrier: SCFHP0

Pri Diagnosis: Enter the primary diagnosis code.

2nd Diagnosis: Enter the 2nd, 3rd and 4th diagnosis code, if applicable.

3rd Diagnosis:

4th Diagnosis:

Office Visit: None Initial OV (Consult) Follow Up
 Select one of the following options using the radio button next to the desired selection: None=No office visit requested; Initial OV (Consult)=Consultation office visit; Follow Up=Follow-up office visit(s).

Procedure 1: Qty: Code: Mod: Descr:

Procedure 2: Qty: Code: Mod: Descr:

Procedure 3: Qty: Code: Mod: Descr:

Procedure 4: Qty: Code: Mod: Descr:

Procedure 5: Qty: Code: Mod: Descr:

Procedure 6: Qty: Code: Mod: Descr:

Unknown Procedure:

Specialty: NONE Enter the last name of the physician (or provider entity). A listing will appear. Select the correct provider.

Refer To Spec: Enter a facility when services are performed at the hospital or surgery center.

Refer To Facility:

Priority: a- Routine Click drop-down to select priority of needed for this request.

Requested Service Date: Visits: 1 Exp Date:

Clinical Info: Enter enough pertinent clinical information to justify medical necessity and/or treatment plan. Include description of problem, history of treatment, reason for referral, additional procedures.

5. Click Save Referral to submit the request. A confirmation will appear. Please include this referral # in Box 23 of your billing to prevent any delays with reimbursement.