

PED-I-CARE XXI REFERRAL/AUTHORIZATION REQUEST FORM

MEMBER: _____ DOB: _____ **MED3000**
Member #: _____ PHONE: 1-800-492-9634
PCP: _____ Requesting Provider: _____ FAX: 1-866-256-2015
Phone: _____ Phone: _____
Contact: _____ Contact: _____
Fax: _____ Fax: _____

ICD-9: _____ **CPT(if applicable)** _____

Check if attached: Notes Tests/studies

Referral Requested *INFOSOURCE MAY BE USED*

Referral to: Dr. _____ ** Specialty: _____
 Evaluation / Consult Only treat as necessary

Service / Procedure Authorization Requested

Inpatient admission elective (including planned surgery or procedure)*:

Facility: _____ Date of Adm: _____

Emergent Admission (within 24 hrs./PCP):

Facility: _____ Date of Adm.: _____

Non-par, out of plan or out of area Admission:

Facility: _____ Date of Adm.: _____

Prescribed Pediatric Extended Care: * Facility: _____

Diagnostic imaging: * Facility: _____ DOS: _____

for: MRI/MRA of _____ Endoscopy
 PET Scan of _____ Colonoscopy

Portable X-Ray in Home: * _____ Provider: _____ DOS: _____

DME: * _____ Provider: _____

Private Duty Nursing: #Visits: * _____ Provider: _____

Home Health / Home IV Infusion: Drug: * _____ #Visits _____ Provider:

Visits: _____ Provider: _____

Hospice (Benefits): _____ Diagnosis: _____

PT # Visits: _____ # Units _____ Facility: _____

OT # Visits: : _____ # Units _____ Facility: _____

ST # Visits: : _____ # Units _____ Facility: _____

Applied Behavioral Analysis # of visits _____ Facility: _____

Authorization #: _____ Units: _____ Date Range: _____