

# PRIMETIME HEALTH PLAN PREAUTHORIZATION AND REFERRAL FORM

PCP must make initial referral.  
PCP or Spec. may extend referrals.

**PrimeTime Health Plan**  
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## PREAUTHORIZATION NEEDS TO BE RECEIVED BEFORE THE REFERRAL APPOINTMENT!

**\*\*\*ALL FIELDS ARE MANDATORY AND REQUIRE COMPLETION FOR PROCESSING\*\*\***

Patient: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Group Number: \_\_\_\_\_ I.D. Number: \_\_\_\_\_

### Out Of Network specialist/facility:

Full Name: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
Tax ID: \_\_\_\_\_ ICD-9/ICD-10: \_\_\_\_\_  
NPI: \_\_\_\_\_ Procedure: \_\_\_\_\_  
Specialty: \_\_\_\_\_ CPT: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**\*\*Please include office/visit noted that will provide additional history relative to this referral\*\***

Date	Physician Requesting Referral (Please print full name)	Phone Number	Fax Number
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Address of Requesting Physician	Tax ID	NPI
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Physician's Signature	Are you the Primary Care Office? Yes or No	Person filling out referral
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**Service Requested:**  Office Visit  Inpatient  Outpatient  Ambulatory Surgery  Other \_\_\_\_\_

\_\_\_\_\_ Consultation and Evaluation/ Date of Service (if known): Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Second Opinion / Date of Service (if known): Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Treatment / Procedure / Test (Specify Code: \_\_\_\_\_)

\_\_\_\_\_ Patient Requested Specialist – Specialist and/or Out-of-Network Visit Not Necessary

**\*\*An updated plan of care and progress note must be submitted with request for continued services\*\***

Note: A preauthorization does not guarantee payment or authorize coverage for services not covered through the member's benefit plan. Claims are subject to review upon receipt of the claim/documentation. Reviewed: 11/02; 1/05; 4/06; 5/10; 6/11; 3/13; 5/14; 3/15; 2/18