DESIGN BENEFITS ADMINISTRATORS

Requires immediate action, although not life threatening ☐ URGENT
Diagnostic studies, elective surgeries, consults, and follow-up ☐ ROUTINE

AUTH/TRACKING NUMBER_____
AUTHORIZATION VALID 90 DAYS FROM DATE OF APPROVAL

PATIENT NAME		PATIENT/MEMBER ID NO/ SS#		INSURANCE
ADDRESS	CITY	ZIP	SEX M ___ F___	DOB
PHONE		MOTHER' S FULL NAME (if member is under 21)		

PCP NAME: NAME OF REQUESTING PROVIDER:	REFERRAL TO:
CONTACT PERSON @ OFFICE	ADDRESS
PHONE FAX	PHONE FAX
M.D. SIGNATURE	DATE SIGNED/DATE REQUESTED

ATTACH ANY CONSULTATION REPORTS, X-RAY REPORTS OR ANY PERTINENT DOCUMENTATION TO SUPPORT MEDICAL NECESSITY

NUMBER OF VISITS REQUESTED:	APPT DATES IF KNOWN:
NAME OF SURGICAL FACILITY:	DATE OF SURGERY:
DIAGNOSIS:	ICD-9 CODE:
PROCEDURE REQUESTED:	CPT CODE:
AGE, SEX, HISTORY, PHYSICAL EXAM, DIAGNOSIS, PERTINENT WORK-UP TO DATE, i.e. DIAGNOSTIC STUDIES:	
TREATMENT PLAN:	

COMPLETED BY Design Benefits Administrators

DATE & TIME APPROVED _____	DATE & TIME PENDED _____	INITIAL NOTIFICATION TO PCP DATE/TIME _____
DATE & TIME REVIEWED BY UMC _____	DATE &TIME DENIED_____	WRITTEN NOTICE TO PCP DATE/TIME _____
		WRITTEN NOTICE TO MEMBER DATE/TIME _____
MEDICAL REVIEWER:		**DATE RETURNED:**

UPON ACCEPTANCE OF REFERRAL AND TREATMENT OF THE PATIENT, PHYSICIAN/PROVIDER AGREES TO ACCEPT IPA CONTRACTED RATES. This Referral/Authorization verifies medical necessity only. Payments for services are dependent upon the patient's eligibility at the time services are rendered.

Fax completed referral forms to: Fax **760-205-6871**
Authorizations Department Telephone: **866-202-0505 OPT 3**

PHYSICIAN REVIEWER AVAILABLE TO DISCUSS DECISION AND CRITERIA USED FOR DECISION @ 760-269-3443