



PINAL COUNTY
Wide open opportunity

**PINAL/GILA LONG TERM CARE
REQUEST FOR REFERRAL
COCHLEAR IMPLANTATION
PLEASE FAX ALL REQUESTS TO (520) 866-6717**

MEMBER NAME: _____ MEMBER ID: _____

DOB: _____ OTHER INSURANCE: _____ MEDICARE A B

EPSDT eligible member? Yes NO CRS Eligible member? Yes No

REQUESTED PROVIDER: _____ ID: _____ PHONE: _____ FAX: _____

URGENCY STATUS (see * for definitions of status):

Standard (Based on members' condition – Not to exceed 14 days)

Expedited – Urgent (within 3 days)

Date of Service: _____ Appointment Time: _____

Services Requested:

Diagnosis Code	Requested CPT Code	CPT Code Description	Diagnosis Code	Requested CPT Code	CPT Code Description

Please answer the following questions:

1. What is the diagnosis related to this request referral? _____

2. Reason for referral? _____

3. What more conservative medical therapy has been tried and failed? _____

4. Does member have a diagnosis of bilateral profound sensor neural deafness? Yes No
5. Does member demonstrate the ability to use auditory clues? Yes No
6. Does member have a functioning implant in either ear? Yes No

Please attach the following: (Mandatory)

1. PCP order (if referral form not signed by Physician)
2. Current History and Physical
3. Progress notes related to request for referral
4. Consultation Notes

Referring Provider Information:

Provider Name: _____ ID Number: _____ Contact: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____ Date: _____

PCP/PCP Designee Signature: _____

PCP Remember: It is your responsibility to assure a copy of this consult/treatment is present in your office/facility medical records.

***Standard Authorization Request:** This is a request that P/GLTC provides a decision as promptly as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request. If P/GLTC determines that additional information is needed to process a request and it would be in the member's best interest to pursue this information, P/GLTC will send out a Notice of Extension Letter (NOE) to the member. This letter notifies the member that more time is needed to process the request and that P/GLTC will not take longer than an additional 14 days to reach a decision.

Expedited Authorization Request: A request that P/GLTC provide a decision to the member as promptly as the enrollee's health condition requires, but not later than three working days following the receipt of the authorization request. If P/GLTC determines that additional information is needed to process a request and it would be in the member's best interest to pursue this information, P/GLTC will send out a Notice of Extension Letter (NOE) to the member. This letter notifies the member that more time is needed to process the request and that P/GLTC will not take longer than an additional 14 days to come to a decision.

Referral authorization is not guarantee of payment.