PINAL/GILA LONG TERM CARE
REQUEST FOR REFERRAL

DME/MEDICAL SUPPLY REQUEST FORM

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)

Dates of Service From: ___________________ To:__________________ Diagnosis (ICD-9 Code):___________________

HCPC Code	Description of Product	Medicare Covered? Y or N	Excess Quantity Ordered	Ordered Quantity	Medicare Covered Quantity	ALTCS Covered Benefit Y or N	P/G LTC Contracted Price

Comments (please fax in supporting documents with request):____

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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 heath 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.