



PINAL/GILA LONG TERM CARE
REQUEST FOR REFERRAL
INCONTINENCE SUPPLIES
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)

For Incontinence Supplies, the following questions must be completed:

- 1. What is the age of the member? _____
2. Are the supplies to be used to manage incontinency? Yes [] No []
3. What is the diagnosis causing the member's incontinence? _____
4. What is the frequency of the incontinence?
Total [] Frequent [] Occasional [] Nocturnal []
5. Are the supplies to be used to manage would care? Yes [] No []

If Yes, Describe the wound(s):

Table with 7 columns: LOCATION, STAGE, LENGTH, WIDTH, DEPTH, UNDERMINING, TUNNELING

Referring Provider Information:

Provider Name: _____ ID Number: _____ Contact: _____
Address: _____ City, State, Zip: _____
Phone: _____ Fax: _____ Date: _____

PCP/PCP Designee Signature: _____
Phone: _____ Fax: _____

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.

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.

Referral authorization is not guarantee of payment.