PINAL/GILA LONG TERM CARE
REQUEST FOR REFERRAL

OPTOMETRY/OPHTHALMOLOGY SERVICES

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	Diagnosis Code	Requested CPT Code

Please answer the following questions for **Ophthalmology** requests**:**

1. For Cataract removal:
   a. Is cataract visible by exam, ophthalmoscope or slit lamp? Yes ☐ NO ☐
   b. Does member have decreased visual acuity attributed to cataract that cannot be corrected by lenses to better than 20/70? Yes ☐ NO ☐
   c. If the posterior chamber cannot be visualized at all, has vision been confirmed by potential acuity meter (PAM) reading? Yes ☐ NO ☐
   d. Is member's corrected visual acuity between 20/50 and 20/70? Yes ☐ NO ☐

2. For all other ophthalmology referrals/vision acuity checks:
   a. Disease process related to request: ____
   ____
   b. Presenting problem to be evaluated: ____
   ____

Please answer the following questions for **Optometry** requests:

a. Is member 20 years of age or younger? Yes ☐ NO ☐

b. Is this the first pair of glasses/lenses post cataract removal? Yes ☐ NO ☐

Please attach the following: (Mandatory)
1. Copy of physicians order (if referral not signed by PCP).
2. Last History and Physical
3. Physician progress notes that support reason for referral and/or surgery.

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.