



PINAL COUNTY

Wide open opportunity

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

Member Name: _____ ID# _____ DOB _____

Medicare A B Other Insurance _____

Name of Nursing Home/ALF _____

EPSDT eligible member? Yes No CRS eligible member? Yes No

Service Provider Number: _____ (AHCCCS# of Provider referred to)

Service Provider Name: _____ (Name of Provider referred to)

Service Requested: _____

Date of Service: _____ Appointment Time: _____

Diagnosis Code: _____

Requested CPT Code: _____ Est. Cost: _____

URGENCY STATUS: Standard (Based on members condition-Not to exceed 14 days)
 Expedited-Urgent (within 3 days)

Please indicate if Member has any of the following systemic conditions:
 (Check all that apply to Member)

<input type="checkbox"/> Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)	<input type="checkbox"/>	<input type="checkbox"/> Malabsorption Syndrome
<input type="checkbox"/> Buerger's disease (thromboangilitis obliterans)	<input type="checkbox"/>	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Chronic thrombophlebitis	<input type="checkbox"/>	<input type="checkbox"/> Peripheral neuropathies involving the feet
<input type="checkbox"/> Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/> Pernicious Anemia
<input type="checkbox"/> Hereditary disorder, i.e., hereditary sensory radicular neuropathy, Fabry's disease	<input type="checkbox"/>	<input type="checkbox"/> Traumatic injury
<input type="checkbox"/> Leprosy or neurosyphilis	<input type="checkbox"/>	<input type="checkbox"/> Uremia (chronic renal disease)
	<input type="checkbox"/>	<input type="checkbox"/> Other _____

Is there clinical evidence of mycosis of the toenail? Yes No N/A

If member is ambulatory, do mycotic toenails interfere with ambulation? Yes No N/A

If member is non-ambulatory, does member have a condition that is likely to result in significant medical complications in the absence of treatment for mycotic toenails or other routine foot care? Yes No N/A

If yes, Explain _____

For bunionectomy, please answer the following questions:
 Is there an overlying skin ulceration present? Yes No
 Is there a neuroma secondary to bunion? Yes No

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

Please attach the following: (Mandatory)
 Copy of the physician order (if referral not signed by PCP)
 Most recent history and physical, physician progress notes that document systemic condition.

PLEASE NOTE THE FOLLOWING BEFORE SUBMITTING REFERRAL:
 Members with Medicare as their primary insurance receiving Medicare covered podiatry services WILL NOT require prior authorization
 Members with Medicare as their primary insurance receiving non-Medicare covered podiatry services WILL require prior authorization
 Member with P/GLTC as their primary insurance receiving any podiatry services WILL require prior authorization.

*Standard Authorization Request: A request for which P/GLTC provides a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request with a possible extension of up to 14 calendar days if the member or provider requests an extension of the P/GLTC establishes a need for additional information and delay is in the enrollee's best interest.
 *Expedited authorization Request: A request for which P/GLTC provides a decision to the member as expeditiously as the enrollee's health condition requires, but not later than three working days following the receipt of the authorization request with a possible extension of up to 14 days if the member or provider requests an extension or if P/GLTC establishes a need for additional information and delay is in the enrollee's best interest.