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

MEMBER NAME:____MEMBER ID:______________________________

DOB: _____________________OTHER INSURANCE:__________________________________MEDICARE A ☐ B ☐

REQUESTED PROVIDER: __________________________ID: __________PHONE:______________FAX:____________

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

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:
1. What is the diagnosis related to the request for referral? ____
2. Name of Specialist? ____
3. AHCCCS ID# of Specialist? ____
4. Type of Specialty? ____
5. Reason for referral? ____
6. Indicate therapies attempted to date by PCP and effectiveness: ____________________________________
____
____
____

7. How many times has member seen this specialist for the same problem? ______________________________

Please attach the following: (Mandatory)
1. PCP order (if referral form not signed by PCP).
2. For initial consultation and first follow-up visit, no documentation is necessary other than order from PCP.
3. For the second follow-up visit, attach a copy of the initial consultation and progress notes of subsequent follow-up visits.

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.