



2850 Douglas Road 3rd Floor
Coral Gables, FL 33134
Phone:(800)225-6755

REFERRAL AUTHORIZATION FORM

Authorization #:

Status:

PATIENT INFORMATION

Patient Name:

DOB:

SSN:

Patient ID:

Home Phone:

Address:

Payer ID:

Plan ID:

Benefit Contract:

PCP Name:

PCP ID:

PCP Phone:

Facility ID:

Referral Type:

ORDERING PROVIDER

Name:

Phone:

FAX:

CLINICAL DATA

Primary Diagnosis:

Secondary Diagnosis:

Special Instructions:

Service Requested:

Requested Date of Services:

To:

Eff From Eff Thru Approved Procedures

Approved # of Visits

EMP Coordinator/Manager:

Urgency:

REFERRED TO PROVIDER

Name:

Type:

Address:

Phone:

FAX:

This Referral Authorization Form is NOT a guarantee of payment. Reimbursements is subject the patient's eligibility with the Health Plan at the time of the services is rendered.