CarePlus HEALTH PLANS, INC.

HEALTH SERVICES REFERRAL REQUEST FAX COVER SHEET

□ **Standard (Routine) Request**
□ **Expedited Request - ALL EXPEDITED** Requests (**Must** meet the following CMS definition: The provider or member believes the member's health, life, or ability to regain maximum function is in serious jeopardy under the standard 14 calendar-day organization determination process) **Clinical documentation must be submitted to support EXPEDITED classification. DO NOT USE the following terms: ASAP, Urgent, STAT—these are not CMS organizational determination terms.**

REQUEST DATE: _____ APPT. DATE: _____APPT. TIME_____

SENDER'S NAME:_____ PHONE ( ) _____FAX( )_____

TOTAL PAGES (INCLUDING COVER SHEET: _____ SERVICES NEEDED BY:_____

REQUESTING PROVIDER (PCP OR SPECIALIST)_____PROVIDER#_____

MEMBER LAST NAME:_____ FIRST NAME:_____PHONE ( )_____

ID#_____ DOB_____COMMENTS_____

PLEASE COMPLETE FORM FULLY. CLINICAL NOTES ARE REQUIRED TO SUPPORT SPECIFIC SERVICES—ALL HOSPITAL BASED REQUESTS, SURGERIES, WOUND CARE, CT/PET/MRA, PAIN MANAGEMENT, REHAB, ORTHOTICS, NON-PAR

IS REFERRAL RELATED TO AN ACCIDENT? □ YES □ NO If yes, specify (circle) Auto Work Comp Other

PROVIDER: ☐ **PAR** ☐ **NON-PAR** **FACILITY:** ☐ **PAR** ☐ **NON-PAR**

REFERRED TO PROVIDER	**FACILITY**
REFERRED TO PROVIDER #	**FACILITY ADDRESS**
PROVIDER ADDRESS	
PROVIDER PHONE ( )	**INPATIENT REQUEST** _____
PROVIDER FAX ( )	**OUTPATIENT REQUEST** _____

SERVICE REQUESTED: _____ INITIAL CONSULT _____ FOLLOW-UP _____ FACILITY FEE* _____NUMBER OF VISITS REQUIRED

HEALTH NETWORK ONE PROVIDER AUTH # _____

DIAGNOSIS CODE(S) / DESCRIPTION	PROCEDURE CODE(S) / DESCRIPTION
/	/
/	/
/	/
/	/
/	/

CPHP FAX NUMBERS

MIAMI-DADE COUNTY: (888) 790-9999
CAC FLORIDA MEDICAL CENTERS: (800) 760-8363
BROWARD AND PB COUNTIES: (866) 832-2678
ALL OTHER COUNTIES: (888) 634-3521