Community Health Plan
OF IMPERIAL VALLEY

CHPIV **Use Only**
Data Entry #:

REFERRAL AND SERVICE REQUEST FORM

PHONE (760) 437-6166 **FAX** (760) 563-5187

☐ Routine ☐ Urgent (Referral is considered Urgent when the member's life, health or ability to regain maximum function is seriously jeopardized, based on the prudent layperson's judgment or when the patient's practitioner determines that the member would be subjected to severe pain that cannot be adequately managed without the care that is being requested).

Please fill out this form legibly and completely. Incomplete requests may be returned.

Updated clinical documentation is required.

Today's Date: ☐ **Medi-Cal** ☐ **Medicare**

Patient's Name: ID#: DOB:

Current: Address:

Telephone Number: Alternate Telephone Number:

Type of Referral or Service Requested:

☐ Outpatient ☐ Inpatient ☐ Home Health
☐ DME ☐ In-Office Procedure

Primary diagnosis **ICD-10** code: _____

Secondary diagnosis ICD-**10** code: _____

Specialty Type:	Contracted Provider Being Requested:	Facility or Vendor:
	Phone # Fax #	

Description of service(s) requested:	**CPT** or **HCPCS** codes (To avoid denial or rejection please ensure codes are a benefit at time of request)	Number of Units

(Complete information needed for timely processing)

Referring Provider: _____ **Office Contact:**_____

Phone Number (ext.): _____ **Fax#**_____

Determination will be based on eligibility and plan benefits at the time services are rendered.

PLEASE DO NOT RESUBMIT REFERRAL UNLESS INSTRUCTED BY CHPIV.