



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.

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PLEASE DO NOT RESUBMIT REFERRAL UNLESS INSTRUCTED BY CHPIV.