

**NETWORK MEDICAL MANAGEMENT, INC**



**MEDICAL GROUP FAX NUMBER REQUESTS**

UM Fax Numbers:

Routine: (626) 943-6320

Urgent: (626) 943-6322

REFERRAL REQUEST DATE: \_\_\_\_\_

(Circle One):

ROUTINE  
5 BUSINESS DAYS

URGENT  
72 HOURS

RETRO  
30 DAYS

DATE OF SERVICE: \_\_\_\_\_

**FORM WILL BE RETURNED IF MEMBER'S NAME, ID#, HEALTH PLAN or/and CLINICAL INFORMATION ARE NOT COMPLETE OR NOT LEGIBLE**

**PATIENT INFORMATION:**

Patient Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_ Sex: (M) (F)

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip \_\_\_\_\_ Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_

Health Plan \_\_\_\_\_ Member ID # \_\_\_\_\_ Member Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

PCP \_\_\_\_\_ Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_ Fax ( ) \_\_\_\_\_ - \_\_\_\_\_

Referring Provider Name : \_\_\_\_\_

Referred to Specialty: \_\_\_\_\_

M.D. Office Contact Name: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Services to be provided at: Office = 11, Inpatient Stay = 21, Outpatient Hospital = 22 REQUESTED FACILITY: \_\_\_\_\_

**DIRECT REFERRALS ONLY: (CHECK ONE) ANY FOLLOW VISITS OR PROCEDURES MUST BE PRE -AUTHORIZED BY NMM**

- Well Woman Exam - 99385 (age 18-39)     99386 (age 40-69)     99396 (age 71 and over)     Pregnant OB Care (full term) - 59400
- Mammography - 77057 (40 - 50 years eligible every 2 years)     Chest, Long Bone or KUB X- Rays (indicate CPT)

PATIENT REQUEST     M.D. REQUEST

Diagnosis: \_\_\_\_\_ ICD-10 code(s) \_\_\_\_\_

**Requested Services/Treatments**

Procedure description: \_\_\_\_\_ CPT CODE \_\_\_\_\_

Procedure description: \_\_\_\_\_ CPT CODE \_\_\_\_\_

Clinical Problem & Duration: \_\_\_\_\_

Pertinent Clinical History / Lab / X-Ray: \_\_\_\_\_

Treatment tried/failed: \_\_\_\_\_

Why is this referral or test (s) necessary? \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**FOR USE BY NETWORK MEDICAL MANAGEMENT ONLY**

Authorized/Modified UM Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ AUTH # \_\_\_\_\_

Pended Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Pended Reason: \_\_\_\_\_ Response Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature \_\_\_\_\_

Denied Reason: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ UM Signature: \_\_\_\_\_

Date PCP Notified: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Specialist Notified: \_\_\_\_/\_\_\_\_/\_\_\_\_ Member Notification: \_\_\_\_/\_\_\_\_/\_\_\_\_ by United States Mail

Phoned PCP of Denial: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ Phoned Specialist of Denial: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_

**STATEMENT FOR PROVIDER: Further care must be authorized before it is rendered.** If additional treatment is required contact the referring physician. Additionally, consultant's findings and recommendations **must** be sent to the referring physician. **ALL LABORATORY WORK MUST BE PERFORMED AT QUEST DIAGNOSTICS** Authorization does not guarantee payments: All claims are subject to Eligibility, Contracted provisions and Exclusions. This certificate is good for 60 days from approval day. All Lab work and Imaging studies should be done at a Network Medical Management contracted facility.