NETWORK MEDICAL MANAGEMENT, INC

MEDICAL GROUP FAX NUMBER

(Check One) ☐ APC: (626) 943-6367
☐ ADV: (626) 442-1106
☐ GOM: (909) 595-5867
☐ GSGP: (626) 943-6394

APC URGENT ONLY: (626) 943-6387
GSGP URGENT ONLY: (626) 943-6385

REFERRAL REQUESTE DATE:_____

(Circle One): *ROUTINE* (5 days) *URGENT* (72 hours)

RETRO (30 Days) *STANDING* (5 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 :_____

M.D. Office Contact Name:_____

Phone: (_____)_____-_____ Fax: (_____)_____-_____

Referred to Specialty:_____

Provider Name:_____

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 (New Patient): ☐99385 (age 18-39) ☐99386 (age 40-64) ☐99387 (age 65 and older)
Established Patient: ☐99395 (age 18-39) ☐99396 (age 40-64) ☐99397 (age 65 and older) ☐Pregnant OB Care (full term) - 59400
☐ Mammography: G0202 (Age 40 and older eligible every 2 years) ☐ Chest, Long Bone or KUB X- Rays

☐ 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.

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.

UM decisions are based on standardized criteria. Provider may view criteria upon request. Call 626-282-0288 for more information. **Effective Date: 01-01-2018**