NETWORK MEDICAL MANAGEMENT, INC

MEDICAL GROUP FAX NUMBER REQUESTS

UM Fax Numbers:

Routine: (626) 943-6320
Urgent: (626) 943-6322

REFERRAL REQUESTE 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 :____

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 - **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** ______________________________

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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.**

UM decisions are based on standardized criteria. Provider may view criteria upon request. Call 626-282-0288 for more information.

Effective Date: 12/01/2017