QUALITY HEALTHCARE PARTNERSHIP
PRIMARY CARE REFERRAL FORM

EMPLOYER MAY NOT BE RESPONSIBLE FOR PAYMENT OF NON-COVERED SERVICES EVEN WHEN REFERRED BY THE PRIMARY CARE PHYSICIAN. PLEASE CONTACT THE EMPLOYER OR CLAIMS PAYOR FOR QUESTIONS CONCERNING COVERED BENEFITS

RETROACTIVE REFERRALS WILL NOT BE ACCEPTED

PATIENT INFORMATION:

Patient Name: ________________________ Date of Birth: ________________________

Employee/Subscriber Name: ________________________ Employee SS No:._ ________________________:

QHP EMPLOYER:____

TO BE COMPLETED BY PRIMARY CARE PHYSICIAN:

Name of Specialist: ____

Reason for Consult/Chief Complaint: ____

Number Of Visits Allowed (maximum of six*): ____

* Update required annually for chronic conditions

The following Lab/X-ray results are available and should not be duplicated: CT __________ MRI__________

X-RAYS OR LAB (SPECIFIC)____

THE SPECIALIST IS APPROVED TO PERFORM THE FOLLOWING ADDITIONAL SERVICES:

_____ Hospital Admit _____ Stress Test _____ Lab: ________________

_____PT/OT/Speech Therapy _____ Endoscopy _____ X-Ray: ________________

_____CT/MRI _____ Myelogram _____ Surgical Proc/Type:____________

LENGTH OF TREATMENT: ________________________

PCP SIGNATURE: ________________________ DATE: ________________________

PRINT NAME HERE: ________________________ TELEPHONE: ________________________

TO BE COMPLETED BY SPECIALIST:

This form should be attached to any bills you submit for reimbursement

(NO PAYMENT WILL BE MADE WITHOUT THE REFERRAL FORM. NO EXCEPTIONS.)

Copy and maintain a file copy of insurance identification card for proper submission of filing claims and following precertification guidelines as specified by QHP plan.

Each episode of illness requires an additional referral by the Primary Care Physician. Also, please note the number of visits allowed on this form, as exceeded visits require an additional referral.

Specialist Signature: ________________________ Date: ________________________

Print Name Here: ________________________ Telephone: ________________________

1.Copy File with Referral Physician Claim **2-Employee** **3-PCP**