Astrana Health

HERITAGE PHYSICIAN NETWORKS

HPN IPA FAX NUMBER

ROUTINE: 945-262-0343
URGENT: 945-262-0340

REFERRAL REQUESTED DATE: _____

CIRCLE ONE: ROUTINE (5 days) URGENT (72 hours) RETRO (30 days) STANDING (30 days)

DATE OF SERVICE: _____

FORM WILL BE RETURNED IF THE MEMBER'S NAME, ID #, HEALTH PLAN, OR CLINICALINFORMATIONISINCOMPLETEORINELIGIBLE.

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 Hospital (21), OutpatientHospital (22) REQUESTED FACILITY:_____

DIRECT REFERRALS ONLY: CHECK ONE (ANY FOLLOW UP VISITS OR PROCEDURES MUST BE PRE-AUTHORIZED BY ASTRANA HEALTH)

Well Woman Exam : (New Patient) ☐ **99385** (age 18-39) ☐ **99386** (age 40-64) ☐ **99387** (age 65+)
(Est. Patient) ☐ **99395** (age 18-39) ☐ **99396** (age 40-64) ☐ **99397** (age 65+)

☐ **Pregnant OB Care (full term) – 59400** ☐ **Mammography: 77067 (40yrs and older, every 2 years)** ☐ **Chest, Long Bone 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: _____

STATEMENT FOR PROVIDER: **Further care must be authorized before it is rendered.** If additional treatment is required, contact the referring physician. Additionally, the 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 valid for 60 days from the approval day. All lab work and imaging studies should be done at an Astrana contracted facility.** CAPITATED LAB: **LabCorp**
UM decisions are based on standardized criteria. Providers may view criteria upon request. Call 626-282-0288 for more information.