Completing Referral Request Form -The form has been divided into six (6) parts.

Section 1

Patient Information: captures basic identifying information about the managed care member. This section provides information any provider, whether another physician, laboratory, physical therapy department, etc. needs to know about the patient. This includes the Patient's Name, Date of Birth, Name of the Insurance Company, the patient's Insurance ID Number, Patient Address and Patient Telephone Number. All areas must be completed, or the form will be sent back to the PCP's office, requesting that the omission be completed and that the request be re-submitted.

Section 2

Physician/Provider Information: records information about the Primary Care Physician and the referring provider. The following fields of information should be completed:

Referred To	Write in the Name of Specialist, Medical Group or Facility
Address/Phone	Write in the Address and Telephone Number of the Provider
PCP name	Print the name of the PCP requesting services
PCP Signature	PCP should place his/her signature in this area
Phone/Fax Number	PCP *current* phone and facsimile number - please make sure that the information is correct before submitting the referral
Office Contact	The Office Manager or the person responsible for coordinating the referrals in the PCP's office
Date	The date the Referral Request Form is submitted

Section 3

Requested Service: specifies the service that is being requested by the Primary Care Physician. Please enter applicable information under Description, Setting and Clinical Background. The PCP is also expected to explain the Referral Process to the patient and check off the applicable box once the explanation has been completed. The CPT code for the requested service is required to process the request.

NOTE: One of the "Setting" boxes must be checked and the referral is only valid for the checked service.

Section 4

Clinical Background/Diagnosis: summarizes the clinical conditions that the patient presented to the PCP at the time of the medical assessment and should indicate the medical necessity for the requested service. The ICD-10 code is required to process the request. Please Attach any clinical documentation that shows medical necessity for the requested service as well.

Section 5

Referral Request Status: warns the PCP if any additional information is required in order to process the referral or if any additional actions are to be taken by AHP after review of the Referral Request Form or after completion of Medical Review.

Section 6

"Office Use Only": is only to be completed by the AHP staff. No information should be placed in this area by the PCPs' staff.

Sending the Form
Upon completion of the form, it should be faxed to the Apogee Health Partners UM Office at 773-737-2838. A determination will be input onto a separate form noted as an "Authorization Form." The completed "Authorization Form" will be faxed back to the number listed as being the facsimile number for the PCP.

A copy should be made of the returned "Authorization Form." One copy will be for PCPs' office record and the second copy should be given to the patient to take to the Specialist or Facility.

Additional Services
The Specialist or Facility should provide a report to the primary care physician - this can be written or verbal. If the Specialist feels additional services are needed, he/she should discuss it with the Primary Care Physician. The Primary Care Physician is responsible for giving or obtaining approval for additional services. At no time should the PCP direct the patient to call AHP for, or regarding a referral request. All Referral Requests are PCP initiated.

The HMO standard is that non-urgent medical determinations be made within fourteen (14) days from receipt of all required information. However, the goal of Apogee Health Partners is to return the determination to your offices within five (5) business days from receipt of all required information. Please refrain from marking a Referral Request Form as being "STAT," unless it meets the HMO definition of "STAT", meaning that the service is a life threatening or life endangering situation , which is scheduled to take place immediately, on the date of request. For quality purposes, please refrain from utilizing this term, unless it is truly applicable and appropriate to the patients' healthcare situation.

Receipt of the "AUTHORIZATION FORM" -The AUTHORIZATION FORM has been divided into four (4) parts.

Section 1 – Section 2 will be populated with the same information that was noted on the original "REFERRAL REQUEST FORM."

Section 3

Authorized Services summarizes the service, the number of visits that have been authorized, the authorized setting for the service, the assigned authorization number, the authorization date, the authorization expiration date, as well as the AHP staff signature.

Section 4

Instructions/ Agreements: notes that this form is binding with the Primary Care Physician, Specialist, or Facility. It clearly states that the authorization is not valid for any other service, than that which is noted on the form. It is explained that this form does not confirm eligibility or guarantee payment unless the patient is eligible on the date of service and the service is a covered benefit.

All requests for non-emergent services must be submitted at least three (3) days prior to the date of the service. Also, all requests must be approved prior to any service being scheduled.

Physicians, Specialist and Facilities are also informed that with acceptance of the referral form, the provider agrees to accept Apogee Health Partners' payment as payment in full and will not bill the patient, except for any approved co-payments.

_____ _____

PCP Signature DATE

_____ _____

Office Manager Signature DATE

THIS COMPLETED FORM MUST BE FAXED BACK TO APOGEE HEALTH PARTNERS, SIGNED AND DATED.