2850 S. Wabash Ave Ste 202
Chicago, IL 60616

PH: 773-737-7300
FX: 773-737-2838

REFERRAL REQUEST FORM

Patient Information

Name (Last, First)	Date of Birth	Insurance	Insurance ID Number
Address			Phone

Physician / Provider Information

Referred To		PCP Name	Office Contact
Address			Date
Phone	Fax	Phone	Fax

Requested Services

☐ Referral process explained to the patient by the PCP. Procedure Date ______________

Description

CPT Code(s)

Setting:
☐ Office ☐ Outpatient ☐ Other ______________________________

Clinical Background/Diagnosis

Description

ICD-10 Code(s)

Referral Status

☐ To Medical Director ☐ Clinical Documentation Required ☐ Requested Services Denied, Denial Letter to Follow

Review Date:	AHP Signature

Office Use Only

Date Received	Date Referred for Review	Date Member Notified/Method	Date PCP Notified/Method

Comments/Notes

NOTICE

THIS IS NOT AN AUTHORIZATION FORM. THIS FORM IS SOLEY USED TO REQUEST MEDICAL SERVICES . IT IS FOR APOGEE HEALTH PARTNERS INTERNAL USE ONLY AND SHOULD NOT BE GIVEN OR ACCEPTED AS AN AUTHORIZATION FOR SERVICE(S).