FIRST CHOICE MEDICAL GROUP Referral Request Form

Tel (951) 280-7700 Fax (951) 280-8200

☐ **Routine** ☐ **Medically Urgent - Reason** _____ **MD Signature**:_____

Referral number does not guarantee payment. Member must be eligible at time of service.

Patient Last Name	**First Name**	**Gender**	**D.O.B.**	**Age**

Address	**Phone**	**Subscriber ID # / ID #**
City, State, Zip	**Health Plan**	

REFERRING PROVIDER			**NPI #**
Name		**Address**	
Phone	**Fax**	**Provider Signature Date**	**Office Contact**

REQUESTED PROVIDER (Physician, Facility, Service)			**NPI #**
Name		**Address**	
Phone	**Fax**	**Comments**	

PCP (If different from Referring Provider above)			**NPI #**
Name	**Office Contact**	**Phone**	**Fax**

Diagnosis	ICD-10 Code **MANDATORY**

SERVICES REQUESTED – Please Be Specific (i.e., consult, follow-up, treatment, DME, etc.)

Procedure Code (CPT) **MANDATORY**

THE FOLLOWING MANDATORY INFORMATON MUST BE SUBMITTED TO SUPPORT YOUR REQUEST:

☐ **DOCUMENTATION OF FAILED CONSERVATIVE TREATMENT – NOTES INCLUDING INITIAL TREATMENT AND FOLLOW UP CARE PROVIDED**
☐ **ALL IMAGING STUDIES AND LABS RELATED TO THE ABOVE DIAGNOSIS**
☐ **ALL PERTINENT PREVIOUS CONSULT REPORTS**
☐ **LIST OF MEDICATIONS USED TO TREAT THE ABOVE DIAGNOSIS**

Services Approved are Contingent on Eligibility, Benefits and Billing Guidelines.

Mail claims to: Vantage 2115 Compton Avenue Department 100, Corona, CA 92881-7273