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## 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.**

<b>Patient Last Name</b>					<b>First Name</b>					<b>Gender</b>					<b>D.O.B.</b>					<b>Age</b>									
<b>Address</b>										<b>Phone</b>										<b>Subscriber ID # / ID #</b>									
<b>City, State, Zip</b>										<b>Health Plan</b>																			
<b>REFERRING PROVIDER</b>															<b>NPI #</b>														
<b>Name</b>										<b>Address</b>																			
<b>Phone</b>					<b>Fax</b>					<b>Provider Signature</b>					<b>Date</b>					<b>Office Contact</b>									
<b>REQUESTED PROVIDER (Physician, Facility, Service)</b>															<b>NPI #</b>														
<b>Name</b>										<b>Address</b>																			
<b>Phone</b>					<b>Fax</b>					<b>Comments</b>																			
<b>PCP (If different from Referring Provider above)</b>															<b>NPI #</b>														
<b>Name</b>					<b>Office Contact</b>					<b>Phone</b>					<b>Fax</b>														
<b>Diagnosis</b>										<b>ICD-10 Code MANDATORY</b>																			
<b>SERVICES REQUESTED – <u>Please Be Specific</u> (i.e., consult, follow-up, treatment, DME, etc.)</b>																													
<b>Procedure Code (CPT) MANDATORY</b>																													

**THE FOLLOWING MANDATORY INFORMATION 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