



**METCARE 2010  
IN-NETWORK  
REFERRAL REQUEST FORM**

**FOR PARTICIPATING PRIMARY CARE PROVIDERS ONLY**

Please check insurance type:

**CarePlus CareOne Plan**

**Humana Gold Plus** (Plan number can be found on member ID card)  H5426-001  H5426-002  H5426-008  H5426-019  H5426-013 SNP (Formerly AdvantageCare Plan)  H1036-047

Today's Date: \_\_\_\_\_ Appointment Date: \_\_\_\_\_

Member Information:

**MEMBER LAST NAME:** \_\_\_\_\_ **MEMBER FIRST NAME:** \_\_\_\_\_

**MEMBER ID NUMBER(from card):** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**Member's Primary Care Physician (PCP) Name:** \_\_\_\_\_

**Requesting Provider:** \_\_\_\_\_

Phone w/area code: \_\_\_\_\_ Fax w/area code \_\_\_\_\_

**Services MUST be rendered by PARTICIPATING Specialist / Facility only. ICD9 diagnosis codes and CPT procedures must be listed.**

<input type="checkbox"/> <b>Participating Specialist for Evaluation and Treatment</b> – up to 3 visits within 90 days	<b>Name of Participating Specialist/Facility:</b> _____ <b>TAX ID#:</b> _____										
	<b>Specialty:</b> _____	<b>Phone # w area code:</b> _____									
	<b>Address w/city/zip:</b> _____										
<b>Home Health</b>	<b>Fax request directly to Advocare Health Alliance 800-831-4264 (except Polk County)</b>										
<input type="checkbox"/> <b>Allergy Injections</b> – limited to 6 months	<b>Name of Provider Providing Injections:</b> _____ <b>TAX ID#:</b> _____ <b>Specialty:</b> _____										
<input type="checkbox"/> <b>Therapy</b> limited to <b>ONE</b> Initial Evaluation visit only. Additional visits can be directly submitted by the requesting provider using the In-Network Prior Authorization form located on <a href="http://www.Metcare.com">www.Metcare.com</a>	<b>Type of Therapy:</b> <input type="checkbox"/> Physical <input type="checkbox"/> Occupational <input type="checkbox"/> Speech <input type="checkbox"/> Aquatics										
	<b>Taking place</b> <input type="checkbox"/> Free Standing Rehab Facility <input type="checkbox"/> Specialist Office <input type="checkbox"/> Outpatient Hospital Therapy Unit										
	<b>Name of Participating Therapy Provider:</b> _____ <b>TAX ID#:</b> _____ <b>Address w/city/zip:</b> _____										
<input type="checkbox"/> <b>Orthotics/Prosthetics/Ostomy/DME</b>	<b>Name of Participating Provider:</b> _____ <b>TAX ID#:</b> _____ <input type="checkbox"/> Orthotics <input type="checkbox"/> Prosthetics <input type="checkbox"/> Ostomy <input type="checkbox"/> DME (if over \$750.00, requires Prior Auth) <i>Refer to Quick Reference Guide at <a href="http://www.Metcare.com">www.Metcare.com</a> as faxing information varies by Market.</i>										
	<b>Description of item requested (Must be a Medicare approved and covered item):</b> _____	<b>Units Requested:</b> _____									
<input type="checkbox"/> <b>Dialysis</b> – limited to 1 year	<b>Name of Dialysis Center:</b> _____ <b>TAX ID#:</b> _____ <b>Address w/city/zip and Phone # w/area code:</b> _____										
	<table border="1"> <thead> <tr> <th>ICD 9 DIAGNOSIS CODE(S)/DESCRIPTION</th> <th>CPT PROCEDURE CODE(S)/DESCRIPTION</th> </tr> </thead> <tbody> <tr> <td>/</td> <td>/</td> </tr> <tr> <td>/</td> <td>/</td> </tr> <tr> <td>/</td> <td>/</td> </tr> <tr> <td>/</td> <td>/</td> </tr> </tbody> </table>		ICD 9 DIAGNOSIS CODE(S)/DESCRIPTION	CPT PROCEDURE CODE(S)/DESCRIPTION	/	/	/	/	/	/	/
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**NAME OF FACILITY:** \_\_\_\_\_ **TAX ID #:** \_\_\_\_\_

Payment for services is subject to member benefit limitations and contract exclusions, and is further limited by the member's eligibility at the time services rendered. This referral is not, and shall not be relied upon as, a guarantee of payment.

**FAX COMPLETED FORM TO REFERRAL FAX NUMBER: 1-888-805-0144**