METCARE 2010
IN-NETWORK
SPECIALIST REFERRAL REQUEST FORM
FOR PARTICIPATING SPECIALISTS 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 LAST NAME: ____________________ **MEMBER FIRST NAME:** ____________________
MEMBER ID NUMBER (from card): ____________________ **DATE OF BIRTH:** ____________________

Member's Primary Care Physician (PCP) Name: ____________________ TAX ID #: ____________________
Requesting Provider: ____________________ Phone w/area code: ____________________ Fax w/area code ____________________

Requesting Specialist Physician Name: ____________________ TAX ID # ____________________
Practice Name: ____________________ **Specialty:** ____________________
Phone w/area code: ____________________ Fax w/area code ____________________

Service Requested (if not listed please write in) (must have referral/notification):

☐ Allergy Injections (*6 month time limit*)
☐ Cardiac Cath
☐ Diagnostic Colonoscopy and/or EGD
☐ Diagnostic Mammogram
☐ Dialysis
☐ DME (< $750)____________________
☐ Home Health
☐ Orthotics/Prosthetics/Ostomy
☐ Outpatient Surgery

☐ Participating specialist referring to another par Specialist (*1 visit only*)
☐ Therapy (Eval only) - ☐ PT ☐ OT ☐ Speech ☐ Aquatic
☐ Carotid Doppler
☐ Echo ☐ EKG ☐ Holter Monitor
☐ EEG ☐ EMG ☐ Nerve conduction studies
☐ Ultrasound
☐ X-ray
Must use Prior Authorization Request form for scans

Participating Specialist: ____________________ **Tax ID #** ____________________
Participating Facility/Provider: ____________________ **Tax ID #** ____________________
☐ **ASC** ☐ **Outpatient Hospital** ☐ **Freestanding Radiology Center**
(Note: Member may have higher co-pay when not using free-standing facility)

Description of Procedure/DME item requested: ____________________
Address of facility/provider: ____________________
City/St/Zip: ____________________

*****CPT CODES AND ICD-9 INFORMATION MUST BE PROVIDED*****

ICD 9 DIAGNOSIS CODE(S)/DESCRIPTION	CPT PROCEDURE CODE(S)/DESCRIPTION
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/	/
/	/
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Payment for services is subject to member benefit limitations and contract exclusions, and is further limited by the member's eligibility at the time service is 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