



DIRECT REFERRAL FORM

c/o MedPOINT Management
P.O. Box 572066, Tarzana CA 91357
Phone: 818-702-0100 ♦ Fax: 818-702-9619

FORM MUST BE FULLY COMPLETED BY PRIMARY CARE PHYSICIAN'S (PCP) OFFICE.
AUTHORIZATION IS VALID FOR 90 DAYS FROM DATE INDICATED BELOW.

DATE:	PCP NAME:	M.D.	PHONE #:
PCP ADDRESS:			
PCP NPI NUMBER:		FORM COMPLETED BY: NAME:	PHONE #:
PATIENT NAME:		HEALTH PLAN:	ID #:
PATIENT ADDRESS:			
PATIENT DOB:		PHONE:	
DIAGNOSIS:			ICD 10 CODE:
REASON FOR REFERRAL:			
SPECIALTY PROVIDER:			SPECIALTY TYPE:
SPECIALTY PROVIDER ADDRESS:			PHONE:

SERVICE AUTHORIZED: ONE INITIAL EVALUATION

CPT CODE 99243: MEDI-CAL LINE OF BUSINESS

CPT CODE 99203: COMMERCIAL & MEDICARE LINE OF BUSINESS

THIS FORM MAY ONLY BE USED FOR THE SPECIALTY CATEGORIES BELOW:

<input type="checkbox"/> EKG	<input type="checkbox"/> MATERNAL AFI	<input type="checkbox"/> OBSTETRICS*	<input type="checkbox"/> ORTHOPEDICS (Fracture Care Only)
<input type="checkbox"/> GYNECOLOGY *	<input type="checkbox"/> MATERNAL NST	<input type="checkbox"/> OPTOMETRY 92004 Z2930 V2020 (Care 1st & L A Care/Comm)	<input type="checkbox"/> TAB (Medi-Cal Only)
RADIOLOGY	<input type="checkbox"/> X-RAY Extremity, Flat Plate, Chest:		
	<input type="checkbox"/> ABDOMINAL ULTRASOUND	<input type="checkbox"/> DEXA SCAN	<input type="checkbox"/> OB ULTRASOUND
	<input type="checkbox"/> BREAST ULTRASOUND	<input type="checkbox"/> MAMMOGRAM	<input type="checkbox"/> PELVIC ULTRASOUND
	RADIOLOGY SERVICE PROVIDER:		
	SERVICE AUTHORIZED:		

*All radiology providers require prescription
order form in addition to IPA referral.*

ALL LAB WORK MUST BE REFERRED TO QUEST DIAGNOSTICS.

Direct Referral must be made to a Participating Bella Vista Medical Group IPA Provider.

All services not listed above require prior authorization. NO EXCEPTIONS. Eligibility must be verified at encounter.

* Member may self refer for sensitive services. *Members may self refer to Participating OB/GYN providers. Obstetricians/ Gynecologists can directly refer members for the following services: pelvic ultrasounds, mammograms, DEXA scans, breast ultrasounds, Maternal AFIs and NSTs.

Copy of Form to be given to patient. PCP to enter authorization via MPM Web as Direct Referral or fax authorization to BELLA VISTA MEDICAL GROUP IPA on the same day referral is generated. NOTICE: This form is a guarantee for payment subject to the following exceptions: **CHARGES FOR NON-COVERED SERVICES OR SERVICES RENDERED TO PATIENTS WHOSE COVERAGE IS NO LONGER IN EFFECT ARE THE PATIENT'S RESPONSIBILITY.** Authorization expires in sixty (60) days, Direct Referral Authorization is not valid for providers not participating on the IPA Panel. **ALL FOLLOW-UP CARE MUST BE PRIOR-AUTHORIZED BY THE UTILIZATION REVIEW DEPARTMENT.** This protocol applies even when additional services are provided in conjunction with the initial consultation. **Services related to CCS eligible conditions must be authorized by CCS. BELLA VISTA MEDICAL GROUP IPA is not responsible for payment of services related to CCS eligible conditions.**

Provider Signature: