PRIME HEALTHCARE SERVICES

Charting a new course in hospital management…

EPO Referral Form

Email: RMHReferral@primehealthcare.com
Fax: 215.487.4689 alt: 4221
Member Eligibility: 888.773.7218 Questions: 215.487.4735

Routine ☐ Urgent ☐ Reason for Urgent

PATIENT INFORMATION

Last Name | First Name | DOB | Member ID #

REFERRING PHYSICIAN

Physician Name | EPO Provider ID # | Primary ☐ | Specialist ☐

Office Phone | Office Facsimile | E-mail

Referral Diagnosis

ICD-9 Code | CPT Code | Expected Date of Service (referral good for 45 days from approval date)

Services Requested / Referring Notes (attach supporting documentation as appropriate)

Referring Physician Signature | Date | Person Completing Form

REFERRED TO

Physician or Facility Name | Office Phone | Office Facsimile

In-Network ☐ Out-of-Network ☐ Reason for Out-of-Network Referral

MEDICAL DIRECTOR / UTILIZATION REVIEW

Tracking # | Approved ☐ | Denied ☐ | Signature/Date

Notes