IMPERIAL HEALTH HOLDINGS
MEDICAL GROUP

PRECERTIFICATION/REFERRAL REQUEST FORM

Fax request to (626) 283-5021 or Toll-Free Fax (888) 910-4412 or to check referral status call (626) 838-5100

Date Submitted_____

☐ STANDARD ☐ URGENT

Referring Provider _____ Phone # _____ Fax # _____

☐ OFFICE ☐ AMBULATORY SURGICAL CENTER ☐ OUTPATIENT HOSPITAL REQUESTED DATE OF SERVICE _____

☐ HOME ☐ DME ☐ INPATIENT/ACUTE ☐ REHAB/ LTAC ☐ SNF SCHEDULED ADMIT DATE _____

Member Name (full name) _____ Date of Birth _____

Member ID# _____ ☐ Other Insurance/Worker's Comp_____

PCP Name_____ PCP Phone # _____

Requested Services

CPT/HCPCS Code _____ Qty_____ ☐ units ☐ visits Procedure description _____

CPT/HCPCS Code _____ Qty_____ ☐ units ☐ visits Procedure description _____

CPT/HCPCS Code _____ Qty_____ ☐ units ☐ visits Procedure description _____

CPT/HCPCS Code _____ Qty_____ ☐ units ☐ visits Procedure description _____

Diagnosis

ICD code_____Dx description_____ ICD code_____ Dx description_____

ICD code_____Dx description _____ ICD code_____ Dx description_____

Requested Specialist/Provider

Name_____ Specialty_____

Phone #_____ Fax #_____

Tax ID#_____ NPI #_____

Requested Facility

Facility Name_____ Phone # _____

Tax ID#_____ NPI # _____

Please Attach Clinicals/Therapy/Prescription/Imaging to support Medical Necessity.
Only completed referrals will be processed. Do not combine multiple requests for different specialties in a single fax.
This referral is valid only for services authorized on this form. This Referral Form does not guarantee payment by IHHMG or the Health Plan. Responsibility for payment shall be subject to member eligibility, benefit limitations, and the interpretation of benefits under applicable subrogation and coordination of benefits rules. As the Primary Care Physician (PCP), I am referring this patient to you for the above treatment. For any other services it will be necessary to obtain an additional referral authorization.