Type of Referral:
☐ Regular
☐ Stat
☐ Expedited

Coastal Communities Physician Network

P.O. Box 661, San Luis Obispo, California 93406 Ph: 800-604-8754

REGULAR REFERRAL FORM

ALL SECTIONS MUST BE COMPLETED AND ATTACH REQUIRED DOCUMENTS TO ALLOW FOR PROCESSING

MEMBER SERVICES USE ONLY

RECEIVED IN MEMBER SERVICES:	DATE TO UTILIZATION REVIEW:
ELIGIBILITY VERIFIED:	REFERRAL COORDINATOR:

PATIENT DATA:

Patient Name:	Patient Phone:
Patient Address:	Height: Weight:
	Allergies: Yes ☐ No ☐
	List:
Patient ID#: DOB:	

Date of PCP Exam:	PCP or Requesting Provider:	Diagnosis (REQUIRED):	ICD-9 Code (REQUIRED):

HISTORY:

Relevant Clinical Information:

1		3	
2		4	

Reason for Referral:	Specialty:
Facility/Specialist Requested:	
Procedure or Treatment Requested:	CPT Code:
Physician Signature:	Date:

THE FOLLOWING RECORDS ARE BEING FAXED WITH THE REFERRAL | TOTAL PAGES:

☐ X-RAYS ☐ MED RECS ☐ LAB ☐ PCP NOTES ☐ SPEC. NOTES

UTILIZATION REVIEW ACTION

☐ Approved ☐ Denied ☐ Modified ☐ Delayed ☐ Deferred for additional information

Additional information required:

Alternate Plan/Notes:

Approved to Facility/Specialist:	Phone #:
Address:	
Appt Date & Time:	☐ Authorized # of Visits
CPT Codes:	Date:
Utilization Review Signature:	

❖ FAX REFERRAL FORM AND REQUIRED DOCUMENTS TO 1-800-604-8755 ❖

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