CarePlus
HEALTH PLANS, INC.

HEALTH SERVICES REFERRAL REQUEST FAX COVER SHEET

☐ **Standard (Routine) Request**
☐ **Expedited Request**
NOTE: ALL EXPEDITED requests **must** meet the following CMS definition: The provider or member believes the member's health, life, or ability to regain maximum function is in serious jeopardy under the standard 14 calendar-day organization determination process); **clinical documentation must be submitted to support EXPEDITED classification.**

REQUEST DATE: _____ APPT. DATE: _____ APPT. TIME: _____

SENDER'S NAME: _____ PHONE: ( ) _____ FAX: ( ) _____

TOTAL PAGES (INCLUDING COVER SHEET: _____ SERVICES NEEDED BY: _____

REQUESTING PROVIDER (PCP OR SPECIALIST): _____ PROVIDER#: _____

MEMBER LAST NAME: _____ FIRST NAME: _____ PHONE: ( ) _____

ID#: _____ DOB: _____ COMMENTS: _____

PLEASE COMPLETE FORM FULLY. CLINICAL NOTES ARE REQUIRED TO SUPPORT SPECIFIC SERVICES SUCH AS ALL HOSPITAL BASED REQUESTS, SURGERIES, WOUND CARE, CT/PET/MRA, PAIN MANAGEMENT, REHAB, ORTHOTICS, NON-PAR

IS REFERRAL RELATED TO AN ACCIDENT? ☐ YES ☐ NO If yes, specify (circle) Auto Work Comp Other

PROVIDER: ☐ PAR ☐ NON-PAR FACILITY: ☐ PAR ☐ NON-PAR

REFERRED TO PROVIDER	FACILITY
REFERRED TO PROVIDER #	FACILITY ADDRESS
PROVIDER ADDRESS	
PROVIDER PHONE ( )	INPATIENT REQUEST _____
PROVIDER FAX ( )	OUTPATIENT REQUEST _____

SERVICE REQUESTED: _____ INITIAL CONSULT _____ FOLLOW-UP NUMBER OF VISITS REQUIRED _____

DIAGNOSIS CODE (S) / DESCRIPTION	PROCEDURE CODE (S) / DESCRIPTION
/	/
/	/
/	/
/	/

CPHP FAX NUMBERS

MIAMI-DADE COUNTY: (888) 790-9999
CAC FLORIDA MEDICAL CENTERS: (800) 760-8363
BROWARD AND PALM BEACH COUNTIES: (866) 832-2678
ALL OTHER COUNTIES: (888) 634-3521