

Date Received by APN-CT

Referral Authorization Request Form Advantage Plus Network-Connecticut

- PATIENT REQUEST
 Routine (14 Calendar Days)
 Medically Urgent (72 Hours)
 Time Sensitive (72 Hours with Notification to UM)

Please type or print clearly in blue or black ink. Submitted by: _____ # of Pages _____

A. Member Information *All Fields Required*

Patient Name	Member ID	Health Plan	DOB
Patient Address			Phone #

B. Primary Care Physician Information *All Fields Required*

PCP	Phone #
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C. Requesting Provider Information *All Fields Required*

Requesting Physician	Phone #
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D. Requested Provider Information *All Fields Required*

Referred To	Specialty	Phone #
Place of Service		Fax #

E. Diagnosis and Service Requested Information *All Fields Required*

ICD-10 Code(s)	Diagnosis Description	
CPT Code(s)	Service Description	
Date of Service or Admission	<input type="checkbox"/> Second Opinion <input type="checkbox"/> Accident-related injury? Date of injury: _____ <i>If work-related injury, refer to worker's comp provider. Do not submit to NAMM California.</i>	# of Visits or Tx

F. Clinical Information

Reason for Referral/Clinical Notes (Please attach chart notes to document medical necessity.)
Please list.

G. Physician Signature *Form will be returned without signature.*

Requesting Physician's Signature (Referral incomplete without MD or DO signature.)	Date
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Please note: *This form is not a guarantee of payment.* Charges for noncovered services or services rendered to ineligible patients are the responsibility of the patient.

For questions, call UM at 888-556-7048.

Fax referral requests to 855-268-2904.

H. Status (For internal use only.)

Criteria Used:
 MCG
 Health Plan
 CMS
 Internally Developed

Pend
 Approved
 Denied
 Duplicate
 Not Processed; Returned
 Member not effective
 Member could not be identified
 Carve-Out/HP Responsible

Date _____ Initials _____ Ref # _____

Prov Notified:
 Phone
 Date/Time: _____
 Initials: _____
 System Fax
 Manual Fax
 Courier
 Overnight Fax

(Urgent/Exp) Mbr Notified:
 Phone
 Date/Time: _____
 Initials: _____
 Letter
 Date/Time: _____
 Initials: _____

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