



HEALTHFIRST NETWORK
REFERRAL/AUTHORIZATION REQUEST FORM

STAT/URGENT **Standard** **Retro** (service provided)

Referral Line: (850)478-1960 Toll Free: (800)492-9634

Referral Fax: (850)471-2240 Toll Free Fax (866) 256-2015

HEALTHPLAN: WELLCARE HEALTHSPRING COVENTRY/VISTA COVENTRY HEALTHY KIDS

MEMBER: _____ DOB: _____

Member #: _____ Age: _____ Gender: _____

PCP: _____	Requesting Provider: _____
PCP Contact: _____	Requesting Provider Contact: _____
PCP Phone: _____	Requesting Provider Phone: _____
PCP Fax: _____	Requesting Provider Fax: _____

Date of Service/Appointment: _____	Number of Visits Requested: _____
ICD-9 Diagnosis Code: _____	Description: _____
CPT/HCPC Code: _____	Description: _____

Referral Requested (eINFOSOURCE may be used)

Referral to: Dr. _____ Specialty: _____

Evaluation/Consult Only Treat as necessary Non-Participating (include contact info)

Authorization Requested for Service/Procedure

To Provider/Facility Name: _____

Participating Non-Participating (include contact information)

Date of Admit/Service: _____ **Provider/Facility Phone #:** _____

<input type="checkbox"/> Inpatient Admission	<input type="checkbox"/> Outpatient Surgery/Services
<input type="checkbox"/> Elective (includes scheduled)	<input type="checkbox"/> Emergent (in 24 hrs)

Diagnostic Imaging: of _____
 by: MRI/MRA PET Scan OTHER
 Diagnostic /Lab Service: _____
 Endoscopy Colonoscopy

DME Item(s): _____

Home Health Care (specify service provider) Home Therapy PT OT ST Home Health/Home Infusion

Hours: _____ # Days/Week: _____ # Weeks: _____

Authorization Disclaimer: Receipt of this authorization does not guarantee reimbursement. Reimbursement is subject to benefit plan coverage and patient eligibility at the time service rendered.