REFERRAL AUTHORIZATION FORM

☐ Medi-Cal Managed Care (SFHP: SF Health Plan)
☐ Healthy Families (SFHP) ☐ Other: _____

NEMS-MSO – 1520 Stockton Street, San Francisco, CA 94133 – Tel: (415) 352-5045 Fax: (415) 398-1742

Member Information	Name: _____ Date of Birth: _____ SFHP ID #: _____
PCP/Referring Provider	Name: _____ Phone #: _____ Fax #: _____
Specialist	Name: _____ Specialty: _____ Contact Person: _____ Phone #: _____ Ext.: _____ Address: _____ Fax #: _____

CLINICAL INFORMATION

Problem / Diagnosis: _____ ICD-9: _____

This referral is valid for: ☐ One (1) Visit ☐ Two (2) Visits **For** ☐ Consultation ☐ Follow-up ☐ Second Opinion

Reason for Referral: (attach related medical reports as necessary)

PCP Requesting: Signed: _____ Date: _____

This referral is valid for up to six (6) months from the date signed by PCP.

The above area is for PCP/Referring Provider use only. *Authorization does not guarantee patient eligibility. To verify eligibility, call SFHP directly at (415) 547-7810. This is not an authorization for payment. Payments are subject to the patient's eligibility and benefits on the day of service.*

SPECIALIST REPORT

Specialist Signature: _____ Date: _____

For NEMS-MSO Use Only:
Auth #: _____

Copy 1 – Specialist returns to PCP after "Specialist Report" section completed
Copy 2 – Retained by Specialist
Copy 3 – Submit to NEMS-MSO with Specialist's Claim
Copy 4 – Retained by PCP at time of referral