



PCP: Refer members to a Health Plus Specialist

24 HOURS A DAY

Call INFO PLUS @ (800) 450-8753 (Press 1)

- or -

Health Plus Elite Referral and Authorization Request Form

Visit our web site at www.healthplus-ny.org, click *Providers*, then *INFO PLUS*. On the INFO PLUS page, click the option labeled "To make a referral to a participating specialist, click here_____"

Primary Care Physician: Participating Specialist referrals - complete section A and give the form to the member, who will make an appointment with the specialist.

Out-of-network referrals and all other services - complete sections A and B and fax the form to (718) 360-1314.

If you have questions, call the Health Services Department @ (800) 450-8753 (option 3) between 8am - 6pm, Monday-Friday.

1. Member Information Today's date: _____

Health Plus Elite ID #: _____ DOB: _____ ZIP CODE: _____

Last Name: _____ First Name: _____

Diagnosis _____ ICD-9 Code _____ # of visits requested: _____ (limit - max 6 visits)

2. Referring Physician Information:

Health Plus Provider ID# _____ Name: _____

Contact person in office: _____ Phone#: _____ Fax #: _____

Signature of Referring Provider: _____

3. "Referred to" Physician Information:

Health Plus Provider ID#: _____ (go to www.healthplus-ny.org, Providers; Provider Search)

Name: _____ Specialty: _____ Tel: _____

Please complete the following section for Out-of Network Referrals, Admissions or other services:

OUT-OF-NETWORK REFERRAL: Physician name and license# _____

ELECTIVE INPATIENT ADMISSION or **AMBULATORY / OUTPATIENT PROCEDURE:**

Admission Date: _____ Procedure Date: _____ Anticipated Length of Stay: _____

Procedure(s): _____ CPT Code(s): _____

OTHER SERVICES (DME, home care, etc.) - Clinical information must be submitted to make a determination

**If requesting services from a non-participating provider, please indicate the medical necessity for the request:

HEALTH PLUS – HEALTH SERVICES DEPARTMENT REVIEW:

This section must be completed by the Health Plus Health Services Department AND include an authorization number for all services that require prior authorization (refer to the Health Plus Provider Manual for more information):

Approved Number of visits: _____ Authorization# _____

Effective date: _____ **AUTHORIZATION IS VALID ONLY FOR THE ABOVE SERVICES AND # OF VISITS.**

Date: _____ **Completed by:** _____

PLEASE NOTE: This authorization is valid for 180 days from the effective date listed above.

- **Payment is contingent upon this authorization and member eligibility on the date of service.**
- To check member eligibility, go to the Health Plus web site at www.healthplus-ny.org and select the INFO PLUS link under PROVIDERS, or call the Provider Care Center at 1-800-450-8753 and select Option 1.
- For electronic claims, see our web site for EDI Guides. Our Payer ID# is 11324 and WebMD™ is our clearinghouse.
- Send paper claims to: GTESS, P.O. Box 853918, Richardson, TX 75085-3918.