



**Primary Care Physician:**

To obtain a referral to a participating specialist or check a member's eligibility **24 hours a day:**

Call **INFO PLUS** by Phone @ 1-800-450-8753  
Fax confirmation is sent to you and the specialist  
-or-

Visit the Health Plus web site at [www.healthplus-ny.org](http://www.healthplus-ny.org)  
(click *Providers*, then *INFO PLUS*).

# REFERRAL FORM

**Primary Care Physician:** To use this form to request a referral to a participating specialist, complete **Sections 1 and 2 only** and fax this form to (718) 360-1314. Health Services staff are available 8 am to 6 pm, Monday-Friday. **For all other services, including non-participating specialist visits** – complete sections 1, 2 and 3, then fax the form to (718) 360-1314. Or, call our Health Services staff at 1-800-450-8753 from 8 am to 6 pm, Monday through Friday.

**Today's date:** \_\_\_\_\_ Plan:  Health Plus  
**Health Plus Member Information:**  Child Health Plus  
 Health Plus ID #: \_\_\_\_\_ DOB: \_\_\_\_\_  Family Health Plus  
 Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

<b>1</b>	<b>Referring Physician Information:</b>	<b>"Referred to" Physician/Provider Information:</b>
	Health Plus Provider ID# _____	Health Plus Provider ID# _____
	Name: _____	Specialty: _____
	Address: _____	Name: _____
	Phone# _____ Fax: _____	Address: _____
Contact person in office: _____	Phone#: _____ Fax: _____	

**2 SPECIALIST REFERRAL:**  
 Diagnosis: \_\_\_\_\_ ICD9 Code: \_\_\_\_\_ # of visits requested: \_\_\_\_\_ (limit – max 6 visits)

**3 Please complete the following section for admissions or other services:**

**ELECTIVE INPATIENT ADMISSION** or  **AMBULATORY / OUTPATIENT PROCEDURE:**  
 Admission Date : \_\_\_\_\_ Procedure Date: \_\_\_\_\_ Anticipated Length of Stay: \_\_\_\_\_  
 Attending MD: \_\_\_\_\_ Phone #: \_\_\_\_\_ Hospital: \_\_\_\_\_  
 Procedure(s): \_\_\_\_\_ CPT Code(s): \_\_\_\_\_

**OTHER SERVICES (DME, home care, transportation, etc.) - Clinical information:**

**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 Provider Manual for more information):

**Approved** Number of visits: \_\_\_\_\_ Authorization# \_\_\_\_\_  
**Effective date:** \_\_\_\_\_ AUTHORIZATION IS ONLY FOR ABOVE SERVICES AND INDICATED # OF VISITS.  
 **Not Approved** "Request for Additional Information" or "Adverse Determination with Appeal Rights" to follow in 24 hrs.  
**Date:** \_\_\_\_\_ **Completed by:** \_\_\_\_\_

- PLEASE NOTE:**
- 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](http://www.healthplus-ny.org) and select the *INFO PLUS* link under *Providers*, or call our Provider Care Center at 1-800-450-8753 and press 1 for *INFO PLUS* by Phone.
  - Send paper claims to: GTESS, P.O. Box 853918, Richardson, TX 75085-3918.
  - For electronic claims, see our web site for EDI Guides. Our Payer ID# is 11324 and Emdeon is our clearinghouse.