SPECIALIST REFERRAL AND PRE-NOTIFICATION FORM

Please complete this form in full. Fax request to 1-800-973-2321. If you would like to submit notifications online, you can visit www.quantum-health.com/providers. Failure to provide code(s) may delay response.

Patient Information:

Patient name: _____
Last First

Patient phone: _____ Patient date of birth: _____

Employer name: _____ Cardholder ID number: _____

Requesting Physician Information:

Physician name: _____ Physician NPI: _____
Last First

Physician address: _____

Physician phone: _____ Fax: _____ Attention to: _____

Person completing request: _____ Request date: _____
Last First

Contact name: _____ Contact phone/ext.: _____
Last First

Specialist Referral Request:

Specialist name: _____ Specialist NPI: _____
Last First

Specialist address: _____

Specialist phone: _____ Fax: _____ Requested effective date: _____

Diagnosis code: _____ Specialty: _____

Scope of referral: _____ Unlimited visits for one year

Pre-Notification Request:

Please submit any historical/clinical information that supports the need for the requested service(s).

Provider/Facility name: _____

Provider/Facility address: _____

Provider/Facility phone: _____ Fax: _____

Clinical contact: _____ Clinical contact phone/ext.: _____
Last First

Diagnosis code: _____ CPT/HCPC code(s): _____

Place of service: ☐ In-patient ☐ Out-patient ☐ Clinic/Office ☐ DME

_____ Observation: Start date _____ Start time _____

Projected date of procedure _____

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