REFERRAL FORM
Managed Care Plans

PacificSource HEALTH PLANS

Please fax completed form to: (541) 225-3625

Date: _____

(PCP) PRIMARY CARE PROVIDER INFORMATION

Last name: _____ First name: _____

Contact person: _____

Phone: _____ Fax: _____

Address: _____ City/State/Zip: _____

Preference for receiving determination notices: ☐ No Preference ☐ Fax ☐ Mail

PATIENT INFORMATION

Last name: _____ First name: _____

Date of birth: _____ Member #: _____

SPECIALIST INFORMATION

Last name: _____ First name: _____

Specialty: _____ Tax ID: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

REFERRAL INFORMATION

Level of Service (scope):

☐ **(1)** Consultation Only ☐ **(2)** Treatment Only ☐ **(3)** Consult/Medical Treatment ☐ **(4)** Consult/Treatment/Surgery

Requested # of visits: _____ Start date: _____ End date: _____

Primary diagnosis code and description: _____

Secondary diagnosis code and description: _____

_____

Requesting additional visits on referral already in place? ☐ Yes ☐ No If yes, please note all dates used:

_____

Other notes: _____

_____

Health Services Department
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