



# Tuality Health Alliance

## THA PCP/SPECIALIST COMMUNICATION/REFERRAL FORM

Date of Request: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Fax 503-681-1823**

**Tuality Health Alliance (Please check appropriate plan)**

**URGENT**

ATRIO

O.H.P

PROVIDENCE

**\*\*PLEASE INCLUDE CHART NOTES\*\***

**REQUEST WILL NOT BE ACCEPTED WITHOUT CHART NOTES**

**Primary Care Physician**

**Contact Person:**

**PHONE:**

**FAX:**

**Patient Name**

**ID #**

**DOB**

**Referred to Provider**

**Specialty**

**Phone:**

**Fax:**

\*Diagnosis \_\_\_\_\_ ICD-9 \_\_\_\_\_

Consult: \_\_\_\_\_ Number of Visits: \_\_\_\_\_

**Referral Date Span**

Start Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Diagnostics: \_\_\_\_\_ Surgical Option: \_\_\_\_\_

End Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Information required for THA LOS and Pre-authorization. (use for Inpt. or Outpt. facility requests)**

Procedure \_\_\_\_\_ CPT \_\_\_\_\_

Diagnosis \_\_\_\_\_ ICD-9 \_\_\_\_\_

Hospital/Facility \_\_\_\_\_ Outpatient \_\_\_\_\_ Inpatient \_\_\_\_\_ LOS Req. \_\_\_\_\_

Date of Admission \_\_\_\_\_ Other Services (SNF, PT, OT, ST, RT, DME) \_\_\_\_\_

THA Internal Use:  Approved  Denied  Re-Direct Date Range \_\_\_\_\_

Case Management \_\_\_\_\_ Date \_\_\_\_\_ Auth # \_\_\_\_\_

Medical Director \_\_\_\_\_ Date \_\_\_\_\_

All out of plan referrals, additional visits, and pre-authorization procedures must be authorized by THA for claims payment. This is not a guarantee of payment. Eligibility must be in effect at time of service, and all plan provisions apply.