Referral Request Form*

Instructions:

This form may only be used to refer Ultimate Health Plan Members to participating providers, for specific services. Refer to the "No Prior Authorization List" and "Authorization Process Overview" documents for a list of eligible services. Emergency care and/or urgently needed care when our network is not available, or dialysis out of the service area, do not require a referral or prior authorization.

All services not included on "No Authorization List" or services provided out-of-network services require prior authorization. Authorization forms and other related documents are available on the provider page of our website: https://www.chooseultimate.com.

Request Date: ____/_____/_____ Referral Begin Date: _____ End Date: _____
(Default 180 days, if no end date listed)

Member Information

Member ID: UL_____ Member Name: _____

D.O.B_____/_____/_____ Member Phone: _____

Referring Provider

Provider Name: _____

Phone: _____ Fax: _____

Office Contact Name: _____

Referred To/ Servicing Provider

Provider Name: _____ Facility Name: _____

Address: _____

Phone: _____ Fax: _____

Tax ID: _____ NPI: _____

Service Requested and Place of Service

☐ Office Services ☐Freestanding Diagnostic Center (POS 11) ☐DME ☐Therapy ☐ASC
(G0104-G0106, G0120, G0121, G0328 Only)

Primary ICD-10: _____ ICD 10 Description: _____

CPT/HCPCS Code	Description of Procedure or Service	Visits/Frequency

Comments:

*This form is for informational purposes only, no submission to the plan is required. Payment is subject to verification of member eligibility, benefit coverage, and appropriate coding guidelines.

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