

VIVA HEALTH Referral Authorization Form

Attention

This facsimile transmission is private, confidential and intended only of the recipient named here on. If you receive this transmission in error, please contact VIVA Health's Medical Management Dept. at (205) 933-1201 or (800) 294-7780

FAX THIS COMPLETED FORM TO: (205) 933-1232 or (800) 364-0814

Referral #: _____ Expires: _____

Patient Information

Member Name:	Member #:	DOB:	Refer to Provider:	Specialty:
Please check the requested services: <input type="checkbox"/> Evaluation and recommendation <input type="checkbox"/> Evaluate and treat				
<input type="checkbox"/> OPS <input type="checkbox"/> One follow-up visit <input type="checkbox"/> Send report to PCP				
Number of Visits:			Appointment Date:	

Medical Information

Diagnosis:	ICD-9 Code:
Symptoms: _____ _____ _____	
Previous Treatment (if pertinent for referral): _____ _____	
Lab/X-ray Finding)if pertinent for referral): _____ _____	
Medical Record #:	

Authorization

PCP Name:	Phone # (Include Area Code):
Contact Name:	Fax #:

For office use only

PCP Provider #:	Refer to Provider:	
Member Effective Date:	Auth Type:	Extent of Care:
Auth Start Date:	Auth End Date:	# of Visits Approved:
Approved by: _____		Date: _____
Entered by: _____		Date: _____

This referral does not constitute a payment agreement. Coverage is based on the eligibility of the member at the time of service is rendered.