PHP

Patient Name		DOB	PHP#

Referral from (must be a participating provider)

Phone	Fax	Contact Name	
New Request? ☐ Yes ☐ No		Appointment Date	

Dx Code and Description

Referral to	NPI	TIN

Address

Specialty	Has patient been previously treated by this provider?
Phone Fax	☐ Yes ☐ No

Referral request based on:
- ☐ Medical findings by a participating physician
- ☐ Request by an Off-Plan Consultant
- ☐ Patient Request

☐ Other:

Please check one reason for referral:
- ☐ Initial Consultation
- ☐ Surgery
- ☐ Follow-up visit
- ☐ Extension of Requested Services

☐ Other:

Do you anticipate ongoing services from Off-Plan provider   ☐ Yes   ☐ No

Can service(s) be provided in the Service Area by a Participating Physician?   ☐ Yes   ☐ No

Has a participating specialist evaluated this patient?   ☐ Yes   ☐ No

List other provider(s) who have been consulted:		Date
		Date

Has previous testing been done? ☐ Yes   ☐ No

Please attach current history and physical, test results, and all pertinent physicians' notes.

Please provide pertinent information for referral request:

FAX OR EMAIL COMPLETED FORM TO:
Vālenz Health at (260) 918-8219 or Carecustomerservice@Valenzhealth.com