GREAT STATES HEALTH ADMINISTRATORS

PRECERTIFICATION/REFERRAL REQUEST FORM

Fax request to (806) 553-7319 or Toll-Free Fax (877) 273-3112 or to check referral status call (806) 853-8331

Date Submitted_____

☐ STANDARD ☐ URGENT

Referring Provider _____Phone # _____Fax # _____

☐ OFFICE ☐ AMBULATORY SURGICAL CENTER ☐ OUTPATIENT HOSPITAL REQUESTED DATE OF SERVICE _____

☐ HOME ☐ DME ☐ INPATIENT/ACUTE ☐ REHAB/ LTAC ☐ SNF SCHEDULED ADMIT DATE _____

Member Name (full name) _____ Date of Birth _____

Member ID# _____ ☐ Other Insurance/Worker's Comp_____

PCP Name_____PCP Phone # _____ _____

Requested Services

CPT/HCPCS Code _____ Qty _____☐ units ☐ visits Procedure description _____

CPT/HCPCS Code _____ Qty _____☐ units ☐ visits Procedure description _____

CPT/HCPCS Code _____ Qty _____☐ units ☐ visits Procedure description _____

CPT/HCPCS Code _____ Qty _____☐ units ☐ visits Procedure description _____

Diagnosis

ICD code _____Dx description_____ ICD code _____ Dx description_____

ICD code _____Dx description _____ ICD code _____ Dx description_____

Requested Specialist/Provider

Name _____ Specialty _____

Phone #_____Fax #_____

Tax ID# _____ NPI # _____

Requested Facility

Facility Name_____ Phone # _____

Tax ID# _____ NPI # _____

Please Attach Clinicals/Therapy/Prescription/Imaging to support Medical Necessity.
Only completed referrals will be processed. Do not combine multiple requests for different specialties in a single fax.
This referral is valid only for services authorized on this form. This Referral Form does not guarantee payment by GSHA or the Health Plan. Responsibility for payment shall be subject to member eligibility, benefit limitations, and the interpretation of benefits under applicable subrogation and coordination of benefits rules. As the Primary Care Physician (PCP), I am referring this patient to you for the above treatment. For any other services it will be necessary to obtain an additional referral authorization.