Primary Care
ASSOCIATES OF CALIFORNIA
PCAC

Phone: (657) 465-3500
Fax: (657) 413-4110

Today's Date: _____

Referral Request Form

☐ Urgent ☐ Routine ☐ Retroactive Approved Auth: _____

Patient Information

First & Last Name		Date of Birth	Sex (Check One) ☐ Male ☐ Female
Health Plan		Health Plan ID #	
Home Phone #			
Patient Address	City	State	Zip Code

Physician Information

Primary Care Physician Name		PCP Phone #
Requesting Physician Name		Requesting Physician Phone #
Requesting Physician or Facility Name	Phone #	Fax #

Referral

Reason for Referral (Check one) ☐ Consult ☐ Follow Up ☐ Procedure ☐ Supply/DME ☐ Testing

Place of Service (Check one) ☐ Doctor's Office ☐ Home Health ☐ Inpatient Hospital ☐ Outpatient Hospital ☐ Surgery Center ☐ Other: _____

Primary Diagnosis/ICD-10 Codes	Requested CPT/RBRVS/HCPC Codes

Please Attach Chart Notes

Including test results, x-ray, lab results, consultation reports & all relevant clinical information will speed up the review process.

NOTE: Referral must be to a contracted specialist. Initial consult is a 99203

Date of Last Visit to PCP: _____ Date of Last Visit to Specialist: _____

PCP Signature: _____ Specialist Signature: _____

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