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 Department at (205) 933-1201 or (800) 294-7780.

FAX THIS COMPLETED FORM TO: (205) 449-7049

Referral #: ______________________________ **Expires:** ______________________________

Member Name:	Member #:	DOB:	Refer to Provider:	Specialty:

Please check the requested services:	☐ Evaluation and Recommendation	☐ Evaluate and Treat
☐ OPS	☐ One Follow-Up Visit	☐ Send Report to PCP
Number of Visits: **(If Pain Mgmt, Limited to 6 visits/6 months)**	Appointment Date:	

MEDICAL INFORMATION

Diagnosis:	ICD-10 Code:

Symptoms: ______________________________
____
____
____

Previous Treatment (if pertinent for referral): ______________________________
____

Lab/X-Ray Finding (if pertinent for referral): ______________________________
____

Medical Record #:

AUTHORIZATION

PCP Name:	Phone #: ( )
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.