PHP PHYSICIANS HEALTH PLAN
THE INSURANCE YOUR HEALTH DESERVES

Request for Referral to Non-Participating Provider

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? ☐ Yes ☐ No	
Phone	Fax		

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:

MAIL OR FAX COMPLETED FORM TO:
Physicians Health Plan
Attn: Medical Management Department
Thank you for your cooperation.