Referral Form

Referral #_____

Mail Yellow copy of completed form to:
AmeriHealth Caritas Pennsylvania
Claims Processing Department
P.O. Box 7118
London, KY 40742

AmeriHealth Caritas Pennsylvania

Member's Name	Member's ID Number	Member's Date of Birth

Requesting PCP Group Name	PCP Group ID Number

Assigned Laboratory, as indicated on Member's ID Card (required for submission). Please check appropriate box.

☐ Quest ☐ None ☐ Other

AmeriHealth Caritas Pennsylvania members and providers please note:

- Referrals are valid for 180 days from date of Referral Request. Date of Service must not be prior to date of Referral Request.
- This referral form may only be used for referral from a PCP to a participating Specialist. All referrals to non-participating providers require prior authorization.
- Referral by the PCP does not guarantee payment.
- Payment is based on the member's eligibility at the time of service and medical necessity for services performed.
- AmeriHealth Caritas Pennsylvania will only pay for services specifically noted and requested by the PCP and covered under the benefit plan.
- Services rendered without a referral will not be covered by AmeriHealth Caritas Pennsylvania Health Plan.
- Specialists cannot refer to other Specialists. Additional specialty services must be coordinated by the PCP.
- Please refer to the Provider Manual for information on services that do not require a referral.

This member is being referred to:
The following information is required. Please use group or facility name/ID unless provider is a sole practitioner.

Provider Name	Specialty Type	Provider ID Number

Street Address	City	Zip Code

Diagnosis and ICD-9 Code (Please provide all available diagnoses.)

PCP must check ONE of the following:

☐ Referral for CONSULTATION, DIAGNOSTIC STUDIES and TREATMENT
Good for unlimited visits within 6 months (180 days).

☐ Referral for CONSULTATION, DIAGNOSTIC STUDIES and TREATMENT
Number of visits approved (circle one): 1 visit 2 visits 3 visits 4 visits 5 visits Other _____

☐ Therapy Services (Physical, Speech, Occupational). Initial evaluation visit requires a referral.
Physical, Speech and Occupational Therapy exceeding 24 visits in a calendar year requires Prior Authorization.

Comments

Authorizing Signature	Contact Phone #	Referral Request Date

If you have any questions, please call Provider Services at 1-800-521-6007.

Referral submission and inquiry can also be accessed through NaviNet®.
Go to: https://connect.navinet.net

Form 02491 500ACPA-1322-99

White copy - **Primary Care Physician** Yellow copy - **AmeriHealth Caritas Pennsylvania** Pink copy - **Specialist** Gold copy - **Member**