

Managed Care Referral Request Form

South Country Health Alliance

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Patient Name:

Date of Birth:

ID No.:

<p>From:</p> <p>Referring Provider:</p> <p>Tax ID Number:</p> <p>Specialty: _</p> <p>Location:</p> <p>Telephone:</p> <p>Fax:</p>	<p>To:</p> <p>Provider Name:</p> <p>Tax ID Number:</p> <p>Specialty:</p> <p>Location:</p> <p>Telephone:</p> <p>Fax:</p>
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Completed by: _____ **Contact Phone No.:** _____

Diagnosis/ICD 9-Code: _____

Reason for Referral/Procedure: _____

Dates of Service: From: _____ To: _____

- Consults:**
 _____ Visits – up to (5) can be authorized – includes:
 Ancillary Tests (lab, X-ray, etc.)
 MRI/Ultrasound/CT/PET Scan
 Therapy 9PT/OT/Speech/Sports Medicine)
- _____ Visits (beyond 20 visits, include clinical information)

Secondary Prescribing Provider:

- Outpatient Surgical Procedure:**
 Clinic (Location Code – 11)
 Hospital (Location Code – 22)
 Surgery Center (Location Code – 24)

For SCHA Use Only

Referral Note: