



PARTNERSHIP HEALTHPLAN OF CALIFORNIA

360 Campus Lane, Suite 100
Farifield, CA 94534
(707) 863-4133 or (800) 863-4144
(707) 863-4118 FAX

RAF NUMBER

[Empty box for RAF Number]

Referral Authorization Form (RAF)



Member Name:
Date of Birth: ID#:
Member Phone:
Referred to:
Address:
City, Zip:
Telephone:
The consultant name must be the same as that used to bill for these services.

TO BE COMPLETED BY THE REFERRING CLINICIAN

Services requested:
[ ] Consult and / or Continuing Care
[ ] 2 months [ ] 4 months [ ] up to 12 mos.
Is requested provider contracted with PHC.
If Non-Contracted provider, RAF must be approved by PHC before given to member.
[ ] Please call me when you have seen patient.
[ ] I would like to receive periodic status report.
[ ] Call me if procedures or admission planned.
This referral is:
[ ] Urgent: potentially life-threatening condition.
[ ] Indicated: important to health; not life-threatening.

Reason for referral:

Work-up and treatment to date: (Include copies of lab reports, imaging studies, etc.):

Questions I need answered:

[Empty line]

Provisional Diagnosis: Primary ICD-9 /Dx:

Date of Issue: Clinician Signature:
Print Name

Send consult report to: Address City Phone Fax

TO BE COMPLETED BY CONSULTANT

Final Report (please check all that apply)
[ ] My medical record note will be sent to you.
[ ] Typed consultation note will be sent to you.
[ ] I will call you to discuss case.
[ ] Patient was not seen as scheduled on

Preliminary Report:

Plan:

Signature / Print Name Date Seen Phone No. Fax No.