PARTNERSHIP HEALTHPLAN OF CALIFORNIA
4665 Business Center Drive
Fairfield, CA 94534
(707) 863-4133 or (800) 863-4144
FAX # (707) 863-4118
www.partnershiphp.org

Medi-Cal
Referral Authorization Form (RAF)

Member Name: ____________________
Date of Birth: ____________________
Member CIN: ____________________

Specialty Group Name: ____________________
Specialty Group NPI: ____________________
Address: ____________________
City, Zip: ____________________
Telephone: ____________________

**The consultant name must be the same as that used to bill for these services.*

TO BE COMPLETED BY THE PRIMARY CARE PROVIDER

Services requested:
[ ] 12 mo. Consult / Continuing Care Start Date: ___________
Other: From Date: ___________ - To Date: ___________

If Non-Contracted provider, RAF must be approved by PHC before given to member. Please provide H&P, progress notes, and evidence of exhaustion of PHC's contracted, in-network specialists (i.e. denial letters, referral denials).

This referral is:
Urgent (72 hours): potentially life-threatening condition.
Routine (Up to 5 business days): important to health; not life-threatening.

Reason for referral:
Member's Preference
Provider not accepting new patients
Provider not available in network
Specialized procedure/area of expertise
Timely access to provider
Other:

Provisional Diagnosis: ____________________ Current ICD code for primary Dx:

PCP Group Name: ____________________ Group NPI: ____________________

Address ____________ City ____________ Phone ____________ Fax ____________

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBLITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.