



BACP IPA (Santa Clara County)  
FAX NUMBER

ROUTINE: 408-426-2972  
URGENT: 408-426-2977

REFERRAL REQUESTED DATE: \_\_\_\_\_

CIRCLE ONE:    ROUTINE    URGENT  
                         (5 days)    (72 hours)  
  
                         RETRO    STANDING  
                         (30 days)    (30 days)

DATE OF SERVICE: \_\_\_\_\_

FORM WILL BE RETURNED IF THE MEMBER'S NAME, ID #, HEALTH PLAN, OR CLINICAL INFORMATION IS INCOMPLETE OR INELIGIBLE.

PATIENT INFORMATION:

Patient Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_ Sex: (M) (F)

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Health Plan \_\_\_\_\_ Member ID # \_\_\_\_\_ Member Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

PCP \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Fax ( ) \_\_\_\_\_ - \_\_\_\_\_

Referring Provider Name: \_\_\_\_\_

Referred to Specialty: \_\_\_\_\_

M.D. Office Contact Name: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Fax ( ) \_\_\_\_\_ - \_\_\_\_\_

Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Fax ( ) \_\_\_\_\_ - \_\_\_\_\_

Services to be provided at: Office (11), Inpatient Hospital (21), Outpatient Hospital (22) REQUESTED FACILITY: \_\_\_\_\_

DIRECT REFERRALS ONLY: CHECK ONE (ANY FOLLOW UP VISITS OR PROCEDURES MUST BE PRE-AUTHORIZED BY ASTRANA HEALTH)

Well Woman Exam : (New Patient)  99385 (age 18-39)  99386 (age 40-64)  99387 (age 65+)

(Est. Patient)  99395 (age 18-39)  99396 (age 40-64)  99397 (age 65+)

Pregnant OB Care (full term) – 59400  Mammography: 77067 (40yrs and older, every 2 years)  Chest, Long Bone KUB X- Rays

PATIENT REQUEST     M.D. REQUEST

Diagnosis: \_\_\_\_\_ ICD-10 code (s) \_\_\_\_\_

Requested Services/Treatments

Procedure description: \_\_\_\_\_ CPT CODE \_\_\_\_\_

Procedure description: \_\_\_\_\_ CPT CODE \_\_\_\_\_

Clinical Problem & Duration: \_\_\_\_\_

Pertinent Clinical History / Lab / X-Ray: \_\_\_\_\_

Treatment tried/failed: \_\_\_\_\_

Why is this referral or test (s) necessary? \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

STATEMENT FOR PROVIDER: Further care must be authorized before it is rendered. If additional treatment is required, contact the referring physician. Additionally, the consultant's findings and recommendations **must** be sent to the referring physician. Authorization does not guarantee payments: All claims are subject to eligibility, contracted provisions, and exclusions. This certificate is valid for 60 days from the approval day. All lab work and imaging studies should be done at a BACP Santa Clara County contracted facility. CAPITATED LAB: Quest  
UM decisions are based on standardized criteria. Providers may view criteria upon request. Call 626-282-0288 for more information.