

Physicians Integrated Medical Group

**STANDING REFERRAL TO SPECIALIST REQUEST**

Date of Request \_\_\_\_\_ Health Plan \_\_\_\_\_  
PCP \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Requesting MD \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Member Name \_\_\_\_\_ Member DOB \_\_\_ / \_\_\_ / \_\_\_ M F  
Member ID# \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Referral to:** \_\_\_\_\_  
Specialty : \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Diagnoses:**  
(ICD-9 code/description)  
Primary Dx: \_\_\_\_\_  
Secondary Dx: \_\_\_\_\_  
Date of original Dx: \_\_\_\_\_

**Practitioner Treatment Plan:**  
(Complete comments below and attach plan-including CPT codes)

# visits/period: \_\_\_\_\_ / ( Circle One) 3mon 6mon 9mon 1year

Briefly describe what is anticipated on each visit:

Please fax this form to PIMG's Auth Department at (415) 467-9819