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VANTAGE MEDICAL GROUP Referral Request Form SAN DIEGO

Tel(800) 406-6059 Fax (951) 248-4790

Routine Urgent

Referral number does not guarantee payment. Eligibility must be verified at time of service.

Patient Last Name		First Name		Gender	D.O.B.	Age
Address			Phone		Subscriber ID # / ID #	
City, State, Zip			Health Plan			
REFERRING PROVIDER				NPI #		
Name			Address			
Phone	Fax		Provider Signature	Date	Office Contact	
REQUESTED PROVIDER (Physician, Facility, Service)				NPI #		
Name			Address			
Phone	Fax		Comments			
PCP (If different from Referring Provider above)				NPI #		
Name	Office Contact	Phone		Fax		
Diagnosis				ICD-9 Code MANDATORY		

IMPORTANT-ATTACH ALL APPROPRIATE PROGRESS NOTES, LAB AND X-RAY RESULTS TO SUPPORT YOUR REQUEST.

SERVICES REQUESTED – *Please Be Specific* (i.e., consult, follow-up, treatment, DME, etc.)

Procedure Code (CPT) **MANDATORY**

↓ **VANTAGE MEDICAL GROUP Use Only** (Please do not write below this line) ↓

Authorization #	Eligibility Effective Date	Status	Received Date	Decision Date	Exp Date
Comments					

Services Approved are Contingent on Eligibility, Benefits and Billing Guidelines.

Mail claims to: Vantage P.O. Box 85915, San Diego, CA 92186-5915