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VANTAGE MEDICAL GROUP Referral Request Form

Tel (951) 280-7700 Fax (951) 280-8200

Routine Medically Urgent - Reason _____ MD Signature: _____

Referral number does not guarantee payment. Member must be eligible 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-10 Code MANDATORY		

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

Procedure Code (CPT) **MANDATORY**

THE FOLLOWING MANDATORY INFORMATION MUST BE SUBMITTED TO SUPPORT YOUR REQUEST:

- DOCUMENTATION OF FAILED CONSERVATIVE TREATMENT – NOTES INCLUDING INITIAL TREATMENT AND FOLLOW UP CARE PROVIDED
- ALL IMAGING STUDIES AND LABS RELATED TO THE ABOVE DIAGNOSIS
- ALL PERTINENT PREVIOUS CONSULT REPORTS
- LIST OF MEDICATIONS USED TO TREAT THE ABOVE DIAGNOSIS

Services Approved are Contingent on Eligibility, Benefits and Billing Guidelines.
Mail claims to: Vantage 2115 Compton Avenue Department 100, Corona, CA 92881-7273