Medicare Advantra Specialty Office Referrals
Please Fax to:
PRE-AUTH: 800-224-2009

Contact Person:_____

Phone Number:_____**Fax Number:**_____

Member Name			
Member ID #			
Referring Provider – Name/TIN #			
Specialty Provider- Name/TIN # Group Practice Name (if applicable)			
Diagnosis (ICD-9 code if available – why member is being referred)			
CPT Code			
Number of visits requested			
The following to be completed by CHCMO			
Authorization			
To Date **From Date**			
Number of Visits Approved			
CHCMO initials/Date			

Total form completion is required. Partially completed forms will be returned to the "Referring Provider" for completion
Confirmation form will be faxed to "Referring Provider"