Innovative Management Systems

STANDING REFERRAL FORM

13200 Crossroads Pkwy. N., #315, City of Industry, CA 91746
Phone: 323-800-8283 Fax: 323-800-3031

Criteria

1. Has the PCP already consulted the Specialist? ☐YES ☐NO
2. If NO, please consult with PCP prior to submitting this request form.

Once complete, please fax form to IMS MSO's UM Department at 323-798-3031 and include all Supporting Clinical/Documentation and Copy of transition/treatment plan (if applicable). Once a determination is made, the referral shall be made within four business days of the date the proposed treatment plan is submitted.

Please select the IPA/Medical Group:

☐IN PHYSICIANS ☐ALL UNITED MEDICAL GROUP ☐NORTHERN CALIFORNIA PHYSICIANS GROUP ☐VITRUVIAN CARE

REFERRAL DATE:__________________ PCP NAME:_________________________ PCP NPI:___________________

PCP ADDRESS:____ PCP PHONE:_____________________________

MEMBER NAME:_______________________________________ MEMBER DOB:____________________________

HEALTH PLAN:____ MEMBER ID #_____________________________

MEMBER ADDRESS:____

REFFERED FROM:

Referred By Name: ___________________________ NPI#: _______________ Specialty: _________________________
Address: __________________________________ City: ____________________ State: _____ Zip: ____________
Phone: _______________________________ Fax: __________________________________

REFERRED TO:

Referred To Provider/Facility: ___________________________ NPI#: _______________ Specialty: ________________
Address: __________________________________ City: ___________________ State: _____ Zip: _____________
Phone:________________________________ Fax: _________________________________

DIAGNOSIS:	ICD 10 CODES:	DURATION OF TREATMENT:

DESCRIPTION OF CONDITION OR DISEASE:	REASON THIS CONDITION IS LIFE THREATENING:

*Please list below any additional specialist information if there are additional providers involved in the treatment.
____
____

Primary Care Physician Signature: __________________________________ **Date**: _________________

IMS MSO Medical Director Signature: _______________________________ **Date**: _________________

By signing above, I am confirming the PCP, the member, and the specialist(s) are in agreeance and aware of the treatment plan. Any changes to the member's condition or any changes to the request, please notify the IPA.