

PHYSICIAN REFERRAL PROCEDURES

A. *Physician Referral Network*

Upon evaluation of a patient, a primary care physician (PCP) can facilitate specialty care within the Plan, by providing a faxed, mailed or telephonic notice of appointment as needed.

Please see the UM Program description for the number of working days for processing referrals that require authorization based upon their acuity level. All information must be complete. Please review the sample form.

All specialty care **must** be referred within the Plan network to be eligible for Health Plan coverage. For assistance in arranging specialty care, please review on-line Provider Directory.

Mental Health Referrals: After primary care physician makes referral to network Mental/Behavioral Health provider, it is then the responsibility of the Mental/Behavioral Health provider to receive prior authorization from Health Services Division for Mental/Behavioral Health Services.

B. *Access*

SWHP provides for patients to directly access those approved SWHP obstetrical, gynecological, and ophthalmologic practitioners. These practitioners provide only relevant care in their scope of practice and *do not replace the primary care physician*.

Occasionally, a patient who has directly accessed one of the approved Plan specialists may have a problem not identified by the PCP. When that problem is not in the accessed specialty field, the patient *must be referred back to the PCP* for appropriate referral. The PCP in conjunction with patient considerations will determine which specialist is most appropriate for the patient considerations will determine which specialist is most appropriate for their patient.

C. **Out-of-Plan Referrals**

All out-of-Plan referrals require prior approval by the Plan Medical Directors. This is facilitated by completing a SWHP Referral Authorization form and faxing/ mailing to the Health Services Division at 1-866-293-4956 (toll free) and/or 254-298-3090 (local #).

Please attach any additional information that you feel explains the need for the referral and/or clarifies the details of the request.

All referral authorization requests must be signed by referring physician (no signature stamp) and have all the required information or they will be unable to be processed and be returned for completion before being entered and processed by the Health Services Division. If you are unsure about data needed on the form, please refer to the “Operational Definitions” section to the form and/or call 1-888-316-7947 or 254-298-3088.



SWHP Authorization Request Form

When completed with original signature, fax to SWHP HSD at: 1-800-626-3042 or 254-298-3450

(1) From Physician (2) Physician NPI # (6) Request Status(based only on medical status)
Emergent TYPE
Urgent Inpatient (Plan)
Routine Inpatient (Actual)
Elective/Pre-Auth Outpatient
Retrospective 23hr.Observation

(7) To: Phys/Prov. Service Address City/State/ZipCode Phone Fax
(11) Patient Name
(12) Member Number
(13) DOB MRN: Phone
(14) Diagnoses
(15) ICD-9 Codes
(16) Procedure(s)
(17) CPT Code(s)

(*Authorizations will only be given into future contract years when the Member/Employer Group membership renewal information has been finalized with SWHP and service is imminent.) Note: While ICD-9 and CPT Codes are not mandatory (only text of diagnoses and procedures), the actual codes that will be billed assists SWHP in more efficiently processing the requested services for a coverage determination in a timely manner to assist you later in prompt payment of any authorized services.

(18) Referral Requested by: Physician/Provider Member/Patient Other
(19) Service Request is for: Initial Consult F/U to Consult Visit 2nd Opinion Outpt.Visit Only (no tests/procedures)
2nd Opinion Outpt. Visit (to include testing/procedure: Evaluate & Assume Care
Procedure Only Procedure & F/U Visit
Other:

(20) Indication(s)/Justification* [Note: *Attach any pertinent information to assist SWHP in timely processing of the request. If requesting out-of-network services, justification for out-of-network referral, indicating the reason in-network service is not available/appropriate, is required in addition to the clinical indication for the service. Services are subject to coverage, benefit, network, and contract policies and exclusions.]

(21) Signature of Referring M.D. (no stamped signatures accepted)

Note: Members may be financially responsible for services they schedule themselves without a referral (if referral is required by their Evidence of Coverage/Standard Plan Document). Members also will be financially responsible if they receive non-covered benefits without required Plan pre-authorization. All services for tertiary and non-contracted providers or facilities must be prior authorized by SWHP.

(22) SERVICE(S) NOT COVERED or REQUIRES PRIOR APPROVAL (May request written criteria to review)
Coronary CT Angiography
Spine Surgeries (Specify)
Major Joint Replacement(s) (Specify)
Plastic Surgery
Dental/Oral Surgery
Home Infusion Services
Nursing Home or Home Health Physical/Occupation/Speech Therapy
Provider Phone#
Modality Frequency Duration
Skilled Nursing Facility Care at
Reason Duration
Inpatient Rehab at
Reason Duration
Long-Term Acute Care at
Reason Duration
Any Out-of-Network Services
Other or Additional Comments

- 1 **From Physician** - Physician who is requesting SWHP coverage of a service and/or providing a required notification.
- 2 **Physician Number** – National Provider Identification number assigned to participating physician.
- 3 **Phone** - Requesting physician's phone number for Plan to reach them on a routine basis.
- 4 **Fax** - Facsimile (FAX) phone number to physician's office to return and/or request required information as needed.
- 5 **Office Contact Person/Phone#** - Referral Clerk and/or Office personnel that is facilitating request on behalf of the physician/provider
- 6 **Request Status/Type** – the **medical urgency** of request; **not** based upon scheduling/appointment access, unless underlying medical status warrants such **AND/OR** identifies the type of level of request, such as Inpatient-planned vs. actual; Observation levels of coverage request
- 7 **To: Physician/Clinic plus Address** – name of physician, health care provider, hospital or clinic facility to which the referral or request is being directed (to include all identifying information of address, phone, and fax numbers for that entity-**required to process request**).
- 8 **Date of Referral** – actual date request or referral has been made by the requesting physician.
- 9 **Appointment Date (if known)** – date services are scheduled to occur if already arranged by the requesting physician's office.
- 10 **# Requested visits/over time period** – actual number of visits and the end date (or time period) by which these physician-requested services are to be completed. (**Authorizations will only be given into future contract years when the Member/Employer Group membership renewal information has been finalized with SWHP and service is imminent.**) Note: While ICD-9 and CPT Codes are not mandatory (only text of diagnoses and procedures), the actual codes that will be billed assist SWHP in more efficiently processing the requested services for a coverage determination in a timely manner to assist you later in prompt payment of any authorized services.
- 11 **Patient Name** – Actual Member's name that is to receive the services
- 12 **Member #** - Member's SWHP membership number
- 13 **DOB; MRN; Phone** – Date of Birth of the Member/Patient to receive the services; medical record #, if known; current working phone # for Member
- 14 **Diagnosis/Diagnoses** – Member's principle diagnosis as the reason for consult/procedure notification and/or request for prior approval of a service. (May include secondary diagnoses as appropriate.)
- 15 **ICD-9 Codes** – Corresponding Codes to Diagnosis or Diagnoses listed in #14 (**Note: These are not required but assist SWHP in more timely processing of your request and response if you are willing to provide them.**)
- 16 **Procedure(s)** – Actual tests and/or procedures requested to be performed
- 17 **CPT Codes** – Corresponding codes to the conditions listed in #16. (**Note: These are not required but assist SWHP in more timely processing of your request and response if you are willing to provide them.**)
- 18 **Referral Requested by** – Identifies the individual requesting the referral authorization (i.e., is the physician/provider requesting this service or facilitating a Member/Patient personal request OR is there some other source ,such as another consultant , making the request)
- 19 **Service Request is:**
- A **Initial Consult-** Physician visit (one) for initial new patient to evaluate and make recommendations to the requesting provider (**Note: Additional, out-of-network services individually require prior authorization from SWHP to pay and must be requested/outlined separately within this request form.**)
- B **F/U to Consult-** Physician visit (one) as an established patient to review findings of the initial consultation and to make recommendations to the Member/referring physician
- C **2nd Opinion Outpatient Visit Only (No tests/procedures)** One outpatient full 2nd Opinion Visit with Member taking all medical records, labs, tests, reports of scans, invasive procedures, etc. for the visit. No additional services are being requested by the referring physician to be provided by the consulting physician to render the 2nd Opinion.
- D **2nd Opinion Outpatient Visit (to Include Tests/Procedures)** One outpatient full 2nd Opinion Visit with Member taking all medical records, labs, tests, reports of scans, invasive procedures, etc. for the visit; however, with the understanding that additional testing/procedures may be performed to render the 2nd Opinion (**Note: If choosing this option, must list on form any/all anticipated tests/procedures/labs that may be performed and should be considered in this review process.**)
- E **Evaluate & Assume Care** – Physician visit for either initial (new) patient visit or follow-up (established) patient visit, but PCP requests that the consulting physician can perform or request approval from the Plan for care/treatment related to the referral diagnosis for the Plan-authorized effective dates (usually 3-6 months, unless otherwise noted). [**This does NOT mean “assume role as a primary physician”**].
- F **Procedure Only** – Physician visit with the requested specialist and/or the Plan-approved procedure, to include medically necessary lab/x-ray as outlined under “initial/f/u consult” category.
- G **Procedure & F/U Visit** – acknowledges that the referral/consulting physician performing a procedure will need to do a f/u visit, as opposed to the referring PCP or Specialist
- 20 **Indication(s)/Justification** - Physician's documentation of the medical necessity of the requested service (**may submit any pertinent information as an attachment faxed with this request form**). (**Note: clear and complete justification is required for any out-of-network request to prevent an inadvertent denial &/or delay to recontact provider for the information before the request can be processed.**) Services are subject to coverage, benefit, network, and contract policies and exclusions.)
- 21 **Signature of Referring M.D.** – **ORIGINAL SIGNATURE of SWHP-Contracted Physician REQUIRED/No stamps or “initialed” signatures will be accepted.**
- 22 **Services Requiring Prior Approval** - care/treatment that requires authorization from the SWHP Health Services Division for a coverage determination **before services are rendered.** Services are subject to coverage, benefit, network, and contract policies and exclusions.]



SWHP Mental/Behavioral Health Authorization Request Form (Initial and Continued Care Treatment Review)

When completed with original signature, fax to SWHP HSD at: 1-800-626-3042 or 254-298-3450

(1) From Physician _____ (2) Physician NPI # _____ (12) Request Status/Type
 Or Provider (please print) _____
 (3) Phone _____ (4) Fax _____
 (5) Office Contact Person/Phone# _____
 (6) To: Physician/Provider _____
 Service Address _____
 City/State/ZipCode _____
 Phone _____ Fax _____

____ (Medically) Emergent
 ____ (Medically) Urgent
 ____ Routine
 ____ Elective/Pre-Authorization
 ____ Retrospective Review

(7) Date of Referral _____
 (8) Patient Name _____ Phone _____
 (9) Member Number _____
 (10) DOB _____ MRN: _____
 [Case ID #-if known: _____]
 (11) Member's Current Location/Level of Care _____

Request Type
 ____ 23 Hr. Observation
 ____ Outpatient Only
 ____ Intensive Outpatient Program
 ____ Initial or Concurrent Inpatient
 ____ Day Treatment Program
 ____ Partial Hospitalization Program
 ____ Crisis Stabilization
 ____ Residential Treatment

(13) Medications:

Name	Dose	Frequency	Start	End
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

(14) Diagnoses : Axis I _____
 Axis II _____
 Axis III _____
 Axis IV _____
 Axis V _____

(15) Procedure(s) Requested _____

(16) CPT Code(s) _____

(17) Next Appt. Date _____ (if known)
 (18) Number of Sessions To-date: _____

(19) # Requested Visits _____ over _____ (wks/mos.)*
 (20) Date of Last Session: _____
 (21) Estimated or Actual D/C Date: _____

(22) Service Requested by: __Physician/Provider __ Member/Patient __ Other _____
 (*Authorizations will only be given into future contract years when the Member/Employer Group membership renewal information has been finalized with SWHP and service is imminent.) Note: While actual diagnostic or procedure codes are not required (only text descriptions), receipt of the actual codes that will be billed assists SWHP in more efficient processing of the requested services for a coverage determination in a timely manner to assist you later in prompt payment of any authorized services.

(23) Indication(s)/Justification for Requested Services* [Note: *Attach any pertinent information to assist SWHP in timely processing of the request. If requesting out-of-network services, justification for out-of-network referral, indicating the reason in-network service is not available/appropriate, is required in addition to the clinical indication for the service. Services are subject to coverage, benefit, network, and contract policies and exclusions. Members may be financially responsible for services they schedule themselves without a referral (if referral is required by their Evidence of Coverage or Standard Plan Document). Members also will be financially responsible if they receive non-covered benefits without required Plan pre-authorization. All services for tertiary and non-contracted providers or facilities must be prior authorized by SWHP.]

(24) Brief Summary of Current Clinical Status: _____

(25) List objective therapeutic goals for Member: _____

(26) List new objective goals for Member (if recertification): _____

(27) Criteria for Termination: _____

(28) Indicate if consultation with PCP has occurred:
 Yes, PCP notified of treatment plan PCP not contacted. Reason: _____

(29) _____ Signature of referring M.D. / Provider (no stamped signatures accepted)

- 1 **From Physician** - Physician who is requesting SWHP coverage of a service and/or providing a required notification.
- 2 **Physician Number** – National Provider identification number assigned to participating physician.
- 3 **Phone** - Requesting physician's phone number for the Plan to reach them on a routine basis.
- 4 **Fax** - Facsimile (FAX) phone number to physician's office (to return and/or request required information as needed).
- 5 **Office Contact Person/Phone#** - Referral Clerk and/or Office personnel that is facilitating request for MD/Provider
- 6 **To: Physician/Clinic plus Address** – name of physician, provider, hospital or clinic facility to which the referral or request is being directed (to include address, phone, and fax numbers for that entity-**required to process request**).
- 7 **Date of Referral** – actual date request or referral has been made by the requesting physician.
- 8 **Patient Name and Phone** – Actual Member's name that is to receive the services and current/working phone number where they can be reached.
- 9 **Member #** - Member's SWHP membership number
- 10 **DOB; MRN; and Case ID** – Date of Birth of the Member/Patient to receive the services; Member's Medical Record # (if known); Member's current SWHP Case ID (if known)
- 11 **Member's Current Location/Level of Care** – Member's current location at time request is faxed (i.e., at home waiting on answer; at facility; in physician's office; etc.) and level of care at the time of the request (i.e., in IP Care; Outpt. Care; IOP; Day Tx., etc.)
- 12 **Request Status/Type** – the **medical urgency** of request; **not** based upon scheduling/appointment access, unless underlying medical status warrants such **AND** identifies the type of level of request for service being submitted (i.e., such as Inpatient; Observation, Type of Program levels of coverage request)
- 13 **Medications** – List of significant medications that Member may be on that impacts the evaluation of this request
- 14 **Diagnosis/Diagnoses** – Member's principle diagnosis as the reason for consult/procedure and/or request for prior approval of a service. Axis Diagnosis is based on DSM-IV Codes (May include secondary diagnoses as appropriate.)
- 15 **Procedure(s)** – Actual tests and/or procedures requested to be performed
- 16 **CPT Codes** – Corresponding codes to the procedures listed in #15. **(Note: These are not required, but assist SWHP in timely processing of your request. If you are willing to provide the codes, it assists you later with more accurate claims payment related to the authorization.)**
- **Member Participation in Care** – If concurrent review or extension of service request, please note the participation level of the Member and compliance with the overall treatment plan
- 17 **Next Appointment Date (if known)** –Date services are scheduled to occur if already arranged
- 18 **# Sessions To-Date** – If request is for continued services, # of previous sessions/services rendered by the servicing provider
- 19 **# Requested visits/over time period** – Actual number of visits and the end date (or time period) by which the requested services are to be completed. **(Note: Authorizations will only be given into future contract years when the Member/Employer Group membership renewal information has been finalized with SWHP and service is imminent. Services are subject to coverage, benefit, network, and contract policies and exclusions. Members also will be financially responsible if they receive non-covered benefits without required Plan pre-authorization. All services for tertiary and non-contracted providers or facilities must be prior authorized by SWHP.)**
- 20 **Date of Last Session** – Date Member was last seen by the provider requested to deliver services
- 21 **Estimated or Actual Planned D/C Date** – If planned series of treatments or defined program, the date of discharge for the Member tentatively planned
- 22 **Service Requested by** – Identifies the individual requesting the referral authorization (i.e., is the physician/provider requesting this service or facilitating a Member/Patient personal request OR is there some other source, such as another consultant, requesting the service)
- 23 **Indication(s)/Justification** - Physician's documentation of the medical necessity of the requested service **(may submit any pertinent information as an attachment faxed with this request form). (Note: clear and complete justification is required for any out-of-network request to prevent an inadvertent denial &/or delay to recontact provider for the information before the request can be processed.)**
- 24 **Brief Summary of Current Clinical Status** – Short statement(s) regarding current clinical status of the Member
- 25 **Objective Therapeutic Goals for the Member** – Goals to be accomplished with the Member if services/program approved
- 26 **New Objective Goals for the Member** – If continued care for recertification, what new goals are to be accomplished with continued care
- 27 **Criteria for Termination** – Critical Criteria/Goals that Member must meet to be able to complete services
- 28 **Consultation with PCP** – Indication of whether PCP (if not the referring physician) is aware of proposed treatment plan for their Member
- 29 **Signature of Referring M.D./Provider** – **ORIGINAL SIGNATURE REQUIRED of SWHP-Contracted Physician/Provider (matches to person in block #1) / No stamps or "initialed" signatures will be accepted.**