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PCP REFERRAL AUTHORIZATION FORM
FOR HMO PLANS ONLY

PCP Auth. No. _____

Instructions: Primary Care Physician must submit PCP Referral Authorization Form to NetCare for review prior to referring patient for the scheduled consult/visit.
 NetCare's HealthCare Management Department will notify the PCP and the Member of the decision within two (2) business days after receiving request.
 For immediate review of urgent referrals, please call NetCare's HealthCare Management Department at (671) 472-3610 x 245.

PATIENT NAME: _____	
POLICY # _____	
DATE OF BIRTH: _____	TEL#: _____

Date of Referral: _____

REFERRED TO NETCARE PROVIDER:

Specialist Name: _____

Clinic Name: _____

Clinic Address: _____

Phone/Fax: _____

Dates of Service: _____

PRIMARY CARE PHYSICIAN:

PCP Name: _____

Clinic Name: _____

Phone/Fax: _____

Dear Colleague:

My office is referring the above named member for reasons noted below:

- Single consultation visit for opinion and recommendation only.
- Number of additional visits _____ (pls. specify). If not specified, three (3) visits will be authorized.
- For diagnostic procedures, please request Prior Authorization from NetCare.
- Please keep me informed of patient's progress.

Please call me if you would like to proceed further than this initial authorization. **NetCare will not cover any service or procedure which are not pre-authorized.** You must contact me **and** NetCare prior to any procedure or hospital admission. All referrals expire sixty (60) days from date of first referred service. Thank you for seeing this patient.

SIGNATURE OF PRIMARY CARE PHYSICIAN

NETCARE WILL NOT BE RESPONSIBLE FOR PAYMENT OF NON-COVERED SERVICES EVEN IF RECOMMENDED BY THE PRIMARY CARE PHYSICIAN (PCP) OR SPECIALIST. (See Group Service Agreement or call NetCare Member Services Department).

REASON FOR REFERRAL

For NetCare Office Use Only

APPROVAL AUTHORIZATION #	Service(s)	Copayment per Visit:
Approved by _____	Date Approved _____	Expires On _____
Request Disapproved <input type="checkbox"/> # _____	By: _____	Date: _____

Comments:

CONFIDENTIALITY NOTICE: This communication may obtain information that is privileged, confidential, and/or prohibited from disclosure, and any unauthorized dissemination, distribution, or copying of the communication is prohibited. If this communication is received in error, please call to notify us immediately, and return this copy to us at the address above.