Referral Request

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sanfordhealthplan.com/heartofamerica

SANFORD HEALTH PLAN
Heart of America

Referring Department: ☐ HAMC ☐ HOAJC ☐ Satellite ☐ St. Andrews ☐ Other _____

Patient Information

Patient Name:	Patient Address:		
Patient Member ID #:	City:	State:	Zip:
DOB:	Patient Phone:		

Referral Information

Referred to Physician:			Facility Name:
Address:			Phone Number:
City:	State:	Zip:	Diagnosis:
Number of Visits Requested:			Appointment Date:

Care Request – Please indicate level of care

- ☐ Consultation – A request for an opinion only (one visit)
- ☐ Treatment – A request for diagnostic evaluation and treatment
- ☐ Follow-up – A request for opinion and further treatment if medically indicated
- ☐ Surgery – A request for consultation, surgery, and follow-up
- ☐ Other _____

Reason for Referral Request – Out of Network

- ☐ Service not available at HAMC or contracting facilities
- ☐ Emergency/Urgent Services
- ☐ Patient Request
- ☐ Continuity of Care

Primary Care Provider Signature:	Phone Number:	Date of Referral:

Important Notes:
Referral is valid only for the number of visits and the type of service indicated above. Visits beyond an initial referral may require review of medical records by Sanford Health Plan to determine medical necessity. Failure to preauthorize additional visits or services may result in denial of payment.

Sanford Heart of America Health Plan Use Only

- ☐ Referral approved
- ☐ Referral denied
- ☐ Need more information

Number of visits approved _____

Comments:

Signature of Chief Medical Officer:	Date:

Questions? Call the Utilization Management Department at (800) 805-7938.