SPECIALTY REFERRAL FORM **(For use by Primary Care Providers)**

CHILDREN FIRST MEDICAL GROUP

DATE ISSUED: _____

All Referrals Must Be Made to: Children First Medical Group (CMFG) Contracted Providers

- Routine lab and X-ray services DO NOT require a referral form.
- This form is for services that **DO NOT require prior authorization**. Please refer to the CFMG Prior Authorization list. All surgical procedures require prior authorization from CFMG's Utilization Management Department.
- Services requested on this referral form should be initiated within 60 days of the issue date indicated above and expire in six months.
- The specialist is required to send a report to the PCP regarding findings, treatment and recommendations.

Patient Name:	DOB: _____ ID#
Name of Specialist Referred to:	Type of Specialty:
Address of Specialist:	**Appointment # / SPC Phone #:**
	SPC Fax #:
Name of Referring PCP:	PCP Phone #:
Signature of Referring PCP:	PCP Fax #:
Diagnosis/Reason for Referral:	

CHECK TYPE OF SERVICE TO BE PROVIDED

☐ Initial consultation and report (1 visit).
☐ Initial consultation and report with follow-up for a total of _____ visits (no more than 3).
☐ Ongoing care (e.g., allergy) for _____ visits over the next _____ months (up to 12).
☐ Special procedure, test or treatment as indicated or per Referral Guideline.

EDI Claims
Children First Medical Group
Payer #: 94321

- All laboratory and X-ray studies must be performed by a contracting provider.
- Referrals to non-contracting providers require prior authorization from CFMG.
- Coverage is based on eligibility at time service is provided and within benefit limitation.

For services that require Prior Authorization contact:
CHILDREN FIRST MEDICAL GROUP UTILIZATION MANAGEMENT
9:00am to 5:00pm Monday-Friday

TELEPHONE: 510-428-3489 **FAX: 510-450-5868**

(Rev.04/2023)