HealthCare Partners
Management Services Organization
1225 Franklin Avenue, Suite 100
Garden City, New York 11530
Phone: (516) 746-2200 (888) 746-2200

REFERRAL REQUEST

FAX TO
(516) 746-6433
or
(888) 746-6433

Date: ____________________

Member Information

Name (Last, First MI)	DOB

Address (Street)	City, State ZIP Code

Health Plan: **Member ID:** **Telephone No:** *(include Area Code)*

Referring Physician (PCP or Specialist)		Referred to (HCP or healthplan par-provider)	
Name (Last, First MI)		*Name (Last, First MI)* Integra Partners	
Address (Street, City, State ZIP Code)		*Address (Street, City, State ZIP Code)* 100 Wall Street, Suite 2502 New York, NY 10005	
Area Code & Telephone No.	*Area Code & Fax No.*	*Area Code & Telephone No.* 718-369-0012	*Area Code & Fax No.* 718-287-1229
Specialty	*Are you referring to yourself?* ☐ Yes ☐ No	*Specialty*	

Requested Service(s)

ALL FIELDS IN THIS SECTION MUST BE COMPLETED – INCLUDING MEDICAL NECESSITY FOR REQUEST **Please provide clinical information, chart notes, test results, previous treatments and/or consultation summaries as available to support this request. Failure to provide adequate clinical findings for requested services may result in delay.**

Diagnosis (es) **ICD-9 Code(s):**

Indicate Medical Necessity

Clinical Notes/Reports Attached: ☐ Yes ☐ No

Service(s) Requested

CPT Code(s):

Place of Service: ☐ Office **Facility** *(specify)*: ____________________ ☐ Outpatient *or* ☐ Inpatient

HealthCare Partners will notify you of the determination made on your request for service(s) *(Approved, Denied, Deferred)* via Telephone and Fax or Mail.

Services Not Prior Approved By HCPMSO Are Not Payable

LAB: HIP– Quest Laboratory **LHA – Lab Corp** **IMPORTANT PROVIDER NOTICE** **(HCP Contracted and Non-Contracted Providers)**

The approval of the services indicated above refers only to the medical appropriateness of the requested service(s) and does not represent guarantee of payment. Your acceptance of this referral to provide services to the above-referenced member/patient constitutes your agreement to accept payment in accordance with HealthCare Partners IPA reimbursement fee schedule (which may change from time to time without notice) as payment in full, and look to the member/patient only for payment of applicable co-payment and/or deductibles. Payment is limited to those service(s) specifically authorized; any additional services require further authorization from HealthCare Partners Management Services Organization. You further agree to abide by HealthCare Partners IPA Claims, Quality and Utilization Management policies currently in effect. **REIMBURSEMENT IS SUBJECT TO MEMBER'S ELIGIBILITY TO RECEIVE BENEFITS ON THE DATE OF SERVICE.** **Claims for authorized services must be received within 45 days of the date of service to be considered for payment.**

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