

Referral Authorization Form



PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NONPARTICIPATING PROVIDER. Payment is authorized only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Quartz Medicare Advantage (HMO) Evidence of Coverage.

Mail to: Quartz Medicare Advantage, ATTN: Medical Management, 840 Carolina Street, Sauk City, WI 53583
Phone: (800) 394-5566 | Fax: (608) 881-8397

I. PATIENT DATA

| | | | | |
|------------------------------|--|----------------|-------------------|-----------|
| Patient's Name: | | Date of Birth: | Member ID Number: | |
| Patient's Address: | | City: | State: | ZIP Code: |
| Primary/Other Diagnosis: | | | | |
| Referred to (Provider Name): | | | Specialty: | |
| Facility Name and Address: | | | Phone: | |

II. FOR PROVIDER COMPLETION

SERVICES REQUESTED BY PROVIDER:

- | | |
|---|---|
| <input type="checkbox"/> CONSULT – INCLUDING Lab / X-ray | <input type="checkbox"/> Other diagnostic testing |
| <input type="checkbox"/> CONSULT ONLY – Lab / X-ray to be done at Quartz Medicare Advantage Network Provider | <input type="checkbox"/> Inpatient hospitalization (Quartz Medicare Advantage MUST BE NOTIFIED at time of admission) |
| <input type="checkbox"/> Treatment | <input type="checkbox"/> Procedure |

REASON:

- | | |
|---|--|
| <input type="checkbox"/> Services not available in network | <input type="checkbox"/> Second Opinion – Provider Requested |
| <input type="checkbox"/> Second Opinion – Patient Requested | <input type="checkbox"/> Outreach |
| <input type="checkbox"/> # Visits Requested _____ | <input type="checkbox"/> Other, Explain _____ |
| | _____ |
| | _____ |

Referring Provider's Name: **PLEASE PRINT**

Referring Provider's Signature/Date

Please indicate on line below whom should be contacted and preferred contact information for decision:

- REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that applying the standard time for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Provider Signature

Date

THIS REFERRAL IS NOT VALID WITHOUT AN APPROVAL LETTER/NOTIFICATION FROM QUARTZ MEDICARE ADVANTAGE