



Referral Authorization Form

Attention:

This transmission is private, confidential, and intended only for the recipient named here on. If you receive this transmission in error, please contact VIVA HEALTH's Medical Management Department at (205) 933-1201 or (800) 294-7780.

MAIL THIS COMPLETED FORM TO: VIVA HEALTH

Attention: Medical Management | 417 20th Street North, Suite 1100 | Birmingham, Alabama 35203

Referral #: _____ Expires: _____

Member Name:	Member #:	DOB:	Refer to Provider:	Specialty:
Please check the requested services:		<input type="checkbox"/> Evaluation and Recommendation	<input type="checkbox"/> Evaluate and Treat	
<input type="checkbox"/> OPS		<input type="checkbox"/>	<input type="checkbox"/> Send Report to PCP	
Number of Visits: (If Pain Mgmt, Limited to 6 visits/6 months)		Appointment Date:		

MEDICAL INFORMATION

Diagnosis:	ICD-10 Code:
Symptoms: _____ _____ _____ _____	
Previous Treatment (if pertinent for referral): _____ _____	
Lab/X-Ray Finding (if pertinent for referral): _____ _____	
Medical Record #:	

MEDICAL INFORMATION

PCP Name:	Phone #: ()
Contact Name:	Fax #: ()

FOR OFFICE USE ONLY

PCP Provider #:		Refer to Provider:	
Member Effective Date:	Auth Type:	Extent of Care:	
Auth Start Date:	Auth End Date:	# of Visits Approved:	
Approved by:		Date:	
Entered by:		Date:	

This referral does not constitute a payment agreement. Coverage is based on the eligibility of the member at the time service is rendered.