SUFFOLK COUNTY DEPARTMENT OF HEALTH SERVICES

REQUEST FOR CONSULTATION/REFERRAL

To Specialist:

Name:_____

Address:_____

_____

Phone#_____

From PCP:

Name:_____

Address:_____

_____

_____

_____

_____

Phone#_____

PATIENT TELEPHONE #

Check Appropriate Insurance Box, Enter # and # of Visits: ❑PCAP ❑Medicaid ❑**SHP/Medicaid** ❑**SHP/CHP** ❑**SHP/FHP** **Number of Visits:** _____

❑Medicare: **#** _____

❑Private Ins. Name _____

CIN or Ins. # _____

❑Suffolk County Voucher ❑CSP E/W ❑Self Pay

REASON FOR REFERRAL:

Print Name Signature/Title Date

Call 1-800-250-5007 For SHP Required Precertification Authorization for the procedures listed below. For a complete listing of services that require precertification please refer to the SHP PROVIDER BENEFIT AUTHORIZATION AND REFERRAL GUIDE.

❑ HOME HEALTH CARE ❑ DME greater than $250 purchase or any rental

❑ SPEECH THERAPY (after 1st visit) ❑ OUT OF NETWORK **AUTHORIZATION#**_____

ASSESSMENT/RECOMMENDATIONS: Please include patient's date of birth on all correspondence.

Date Consultation Report sent to PCP: _____/_____/_____
MM DD YY

_____

Print Name Phone # Signature/Title Date

Health Center Instructions

1. Give the patient *white* & *yellow* copies to bring to the specialist
2. Retain *pink* copy in medical record until *white* copy is returned – discard *pink* copy
3. For SHP Members, **Fax a copy of the completed form to 1-888-892-6130 on same date patient is seen by you.**

Specialists Instructions: for all Patients:

1. Complete form & return *white* copy to referring provider/health center

2. Retain *yellow* copy for your files

For SHP Patients you must also:

3. Verify eligibility on date of service.

4. Fill in your Tax ID # _____

5. MAIL THIS FORM WITH YOUR CLAIM TO SHP, PO BOX 6008, HAUPPAUGE, NY 11788-9007 OR FAX TO 1-888-892-6130.

If you are an Out of Network provider and did not get an approval letter from SHP UM, call 1-800-250-5007

NOTE: THIS REFERRAL IS GOOD FOR SIX (6) MONTHS FOR ALL PARTICIPATING PROVIDERS IN YOUR TAX ID.