

The Employers' Coalition on Health (ECOH) Referral Form

REFERRAL FAX: (815) 395-8107
REFERRAL PHONE: (815) 397-5395

Date of Request _____

PATIENT INFO (All fields required)

PT NAME _____	<input type="checkbox"/> Spouse	SUBSCRIBER NAME _____
DOB _____	<input type="checkbox"/> Dependent	SUBSCRIBER ID# _____
PT ADDRESS _____		EMPLOYER (ECOH Member Co.) _____
CITY, ST. ZIP _____	<input type="checkbox"/> RIVER VALLEY	<input type="checkbox"/> NETWORK

IN NETWORK REFERRAL

PCP/REFERRING Dr. _____ <small>(Required)</small>	PHONE# _____ <small>(Required)</small>
PROVIDER REFERRED TO _____ <small>(Required)</small>	PHONE# _____ <small>(Required)</small>
DIAGNOSIS _____ <small>(Required)</small>	DX CODE _____ <small>(Required)</small>
Clinical Summary/Comments <small>(Required)</small> _____	

INFORMATION SENT (Required)

<input type="checkbox"/> LAB REPORTS	<input type="checkbox"/> X-RAYS	<input type="checkbox"/> LIPIDS	DATE OF SERVICE <small>(Required)</small> _____ to _____
<input type="checkbox"/> CHEM SCREEN	<input type="checkbox"/> CBC	<input type="checkbox"/> OTHER _____	<input type="checkbox"/> 3 MONTHS <input type="checkbox"/> 6 MONTHS
<input type="checkbox"/> PCP CLINICAL INFORMATION	<input type="checkbox"/> ECG		

Form Faxed to Specialist Office *Form Faxed Hines (ECOH Referral Office)*

OUT OF NETWORK REFERRAL

PCP/REFERRING Dr.: _____ <small>(Required)</small>	PHONE# _____ <small>(Required)</small>
PROVIDER REFERRED TO _____ <small>(Required)</small>	PHONE# _____ <small>(Required)</small>
DIAGNOSIS _____ <small>(Required)</small>	DX CODE _____ <small>(Required)</small>

JUSTIFICATION FOR OUT OF NETWORK REFERRAL: This must be detailed, may send letter or summary of previous treatment. (Required)

INFORMATION SENT (Required)

<input type="checkbox"/> LAB REPORTS	<input type="checkbox"/> X-RAYS	<input type="checkbox"/> LIPIDS	DATE OF SERVICE <small>(Required)</small> _____ to _____
<input type="checkbox"/> CHEM SCREEN	<input type="checkbox"/> CBC	<input type="checkbox"/> OTHER _____	<input type="checkbox"/> 3 MONTHS <input type="checkbox"/> 6 MONTHS
<input type="checkbox"/> PCP CLINICAL INFORMATION	<input type="checkbox"/> ECG		TYPE OF SERVICE REQUESTED <small>(Required)</small>
			<input type="checkbox"/> Second/Third Opinion <input type="checkbox"/> Consult & Recommendation
			<input type="checkbox"/> Treatment <input type="checkbox"/> Surgery

Form Faxed Hines (ECOH Referral Office)

Referring Provider Signature _____ Date _____

ECOH OFFICE ONLY

APPROVED (Subject to member eligibility and benefits at time of service)

DENIED

A network provider can provide services

Call claims payer/Other

An appeal/grievance process is available through your health plan. Please refer to the subscriber agreement handbook regarding the proper procedure.

Medical Director Signature _____ Date _____