Prestige HEALTH CHOICE®

Leading the Way to Quality Care

Referral Form

Member Information

Member Number:	Member Last Name:	Member First Name:
Date of Birth:	Gender ☐ Male ☐ Female	Phone Number:

Provider Information

Primary Care Physician Name:	PCP Number:	County:
Phone:	Fax:	

Specialist Information

County:	Type (Specialty):	(Specialist) Provider:
Provider Phone:	Provider Address:	
Diagnosis- ICD-9 (ICD-10 after 10/1/14)		
Evaluation Only ☐	Evaluation Plus Visit #	Time Frame: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 1 year

Background Description

Service Requested & Reason for Referral