Facey Medical Group
Service Request Form Orientation

Checklist for Required Fields:

- Form is to be used for all HMO service requests – both internal and external
- Form is to be completed by the physician only.
- Note that anything in a box is absolutely required information. The referral WILL NOT be processed without these areas being completed.

1. Top of Form **(Required)**

    a. Check Routine 1 (for appt w/in 15 business days), or Routine 2 (for appt w/in 7 to 10 business days). **Urgent and Stat requests must be called in to Urgent/Stat Line 818-837-5548 or extension 4423.** Check Retro if service/s have been rendered already. Check PR if referral is per patient request.
    b. Note the asterisk noting that certain requests require the DEA number

2. Specialty Services (or Other Services) **(Required)**

    a. **Check consult vs. follow-up**
    b. **Check the type of consult or referral being requested or, if not found, write it in the space provided as "other"**
    c. If you or the patient has a specific provider preference, please specify the name.
        i. If the name is on the Select Provider List, it will auto-auth
        ii. If not, it will go to UM for review
    d. If there is no preference for the specialist, one will be selected from the Select Provider List, favoring Facey physicians. The Select Provider List is stratified by geography.

3. Other Services (or Specialty Service) **(Required)**

    a. *Note the asterisks by certain services. If any of these services are selected, you will need to fill in your DEA number in the space provided.*
    b. **Check the service requested or, if not found, write it in the space provided as "other"**
    c. When ordering imaging studies, BE SPECIFIC: specify the site (brain, LS-spine, Knee, etc.) requiring the imaging.

4. Clinical info to be sent to specialist – check as needed. Attach copies of records, labs.
    (by MD) and ICD-9 (by MA) (Required)

5. **Clinical Indications (Required)**
    a. This information will be transcribed from this form to the IDX generated authorization. It will therefore be available for the consultant on the auth.
    b. Please put concise but PERTINENT AND LEGIBLE information in this area.

6. **Sign and date the form (Required)**

7. *Place your DEA number in the provided space if you checked an item with an asterisk(*)*

8. Level of Service and Place of Service needs completion for services in hospitals or surgery centers

9. Specialty Provider's Name – if desired – or will be entered by the SRS

10. **Patient Demographic Label (Required)**

    a. Place Label or, at a minimum, print information in the bolded areas