COMMON GROUND
HEALTHCARE COOPERATIVE

EPO REFERRAL FORM

To be completed by In-Network Provider Only. Referrals to out-of-network providers will only be approved if there is no in-network provider available to perform the medically necessary service.

Please complete this form fully to prevent delays in review. Referral must be approved by CGHC prior to the member receiving care. An approved referral is not a guarantee of coverage. If Prior Authorization is required, this must be completed separately by calling 877.779.7598.

DATE OF REQUEST:		**REFERRAL FORM COMPLETED BY:**
Patient Name:	Member ID Number:	Patient Date of Birth:
Patient Address:		
Patient Email Address:		Patient Phone Number:
REFERRING PHYSICIAN INFORMATION		
Referring Physician Name	Referring Physician Clinic Name:	Referring Physician Specialty:
Referring Physician Address:		
Office contact person name:	Phone number: Fax number:	Email:
REFERRING TO INFORMATION		
Physician Name:	Location where care will be provided:	Specialty:
Address:		
Office contact person name:	Phone number: Fax number:	Email:
CLINICAL INFORMATION		
Diagnosis Description:	ICD 10 Code(s): Procedure Code(s):	
Type of care requested:	Dates of service: From ____ /____/_____ to ____ / ____ / _____ Service is required within 72 hours: □ Yes ■ No	
Reason for referral to out-of-network provider:		
FOR INTERNAL USE ONLY		
□ Approved □ Denied DOS approved: From ____ /____/_____ to ____ / ____ / _____ Prior Authorization Required: □ Yes □ No Prior Authorization Approved: □ Yes □ No Notes:		

Send encrypted email to CGHCReferrals@CommonGroundHealthcare.org
fax to 262.754.9690 or mail to: CGHC, Attn Referrals, PO Box 1630, Brookfield, WI 53008-1630