COMMON GROUND
HEALTHCARE COOPERATIVE

EPO REFERRAL FORM

This form must be completed by an in-network provider. Referrals to out-of-network providers may be approved if no in-network provider is available to perform a medically necessary service.

Clinical notes must be submitted with the form. Any referrals received without clinical notes will be denied.

Referrals to out-of-network providers must be approved by CGHC prior to the member receiving care. Approval of a referral is not a guarantee of coverage. If prior authorization (PA) for the service is required, the PA request must be submitted separately.

DATE OF REQUEST: (MM/DD/YYYY)	**REFERRAL FORM COMPLETED BY:**	
PATIENT INFORMATION		
Patient Name:	Member ID Number:	Patient Date of Birth: (MM/DD/YYYY)
Patient Address: Street, City, State, Zip Code		Patient Phone Number: (xxx)xxx-xxxx
IN-NETWORK REFERRING PHYSICIAN INFORMATION		
Referring Physician Name:	Referring Physician Clinic Name:	Referring Physician Specialty:
Referring Physician Address: Street, City, State, Zip Code		
Office Contact Name:	Phone Number: (xxx)xxx-xxxx	Fax Number: (xxx)xxx-xxxx
REFERRING TO INFORMATION		
Physician Name:	Specialty:	
Referred to Physician Clinic Name:	Address: Street, City, State, Zip Code	
Office Contact Name:	Phone Number: (xxx)xxx-xxxx	Fax Number: (xxx)xxx-xxxx
CLINICAL INFORMATION		
Diagnosis Description:	ICD 10 Code(s):	Procedure Codes:
Type of Care Requested:	Dates of Service: From to Service is required within 72 hours: □ Yes □ No	
Summary of reason for referral to out-of-network provider *(must be supported in clinical notes provided):*		
FOR INTERNAL USE ONLY		
□ Approved □ Denied DOS Approved: From to Prior Authorization Required: □ Yes □ No Prior Authorization Approved: □ Yes □ No Notes:		

Fax EPO Referral form AND clinical notes to (262) 754-9690, Attn: Referrals
Email: CGHCReferrals@CommonGroundHealthcare.org
Mail: CGHC, Attn: Referrals, PO Box 1630, Brookfield, WI 53008-1630