*** Validate eligibility prior to referral. If member is assigned to an IPA/Medical Group you must refer to the IPA's policy for referral authorization.**

DIRECT REFERRAL TO SPECIALIST*

Patient Name :	Date :
DOB:	Member ID # :
Address:	☐ Healthy Familes ☐ Medi-Cal
Phone:	

Direct Referral is only valid to a Molina Healthcare Contracted Provider

Referred To :	Specialist Phone # : ( )
Specialty :	Specialist Fax # : ( )
Address :	Appointment Date : _____

Clinical Reasons for Referral : (Attach all necessary clinical information to this referral)

Diagnosis :	ICD-9 CODE :

Referred By (MD) :	Referring MD Phone # : ( )
	Referring MD Fax # : ( )

THIS REFERRAL IS VALID FOR 30 DAYS ONLY

(Eligibility must be verified at time of service)

Provide original form to Member to be presented to specialist

Forward a copy to Referred to Specialist
Place a copy in the Member's medical record