Molina Healthcare of Florida (MHF)
In-Network Specialist Referral Form

Date:	
Patient Name:	
DOB:	
Member ID:	

THIS REFERRAL IS VALID FOR 90 DAYS OR UP TO 6 MONTHS ONLY.

(A referral is not required for visits to providers with the following specialties – Obstetrics and Gynecology, Dermatology, Chiropractic and Podiatry)

1. Provide original form to Member to be presented to specialist.
2. Forward a copy to requested specialist.
3. Place a copy in Member's medical record.
4. Include all necessary clinical information with this referral.

Diagnosis Description:		**ICD 10 Diagnosis Code:**
Referred To:* _____ *Must refer to a specialist within network **Specialty:** _____ **Address:** _____ _____		**Specialist Phone Number:** _____ **Specialist Fax Number:** _____ **Check one:** **[ ] Standard Referral (up to 3 visits for 90 days)** **[ ] Standing Referral. Enter the number of visits_____. Standing referrals are valid for up to 6 months.**

Clinical Reasons for Referral:

Requesting PCP:	
Phone Number:	
Fax Number:	
Signature:	
Date:	