



Referral Authorization Form

URGENT is a referral request that relates to a medical condition which, if not treated in the next few hours, could adversely affect the member's health/function. If you check this box and CUP determines that this is not an urgent request then it will be processed per our standard procedures.

MEMBER NAME _____ **DOB** _____

DATE OF REQUEST _____ **ID #** _____

Type of Insurance:

- Basic Health
- Basic Health Plus
- Healthy Options

Referral Number: _____

Referred to: _____

Referred by: _____

ICD-9 Code: _____

CPT Code: _____

HCPC Code: _____

Type of Service (consult, dx, f/u appt): _____

Referral Contact Name & Number: _____

Comments: _____

CHART NOTES MUST ACCOMPANY REQUESTS

Submit to fax number (360) 449-8916 or (866) 567-9962

www.cuphealth.com