1120 W. La Veta Ave., Ste 450 • Orange, CA 92868• (714) 565-5100 • (860) 907-2202

CHOC Health Alliance Referral Form

Referring Provider: Complete this form and forward to the specialist office to whom you are referring the member. Retain a copy of the completed form in the member's medical record.

Note: To ensure proper payment of rendered services, the *recipient* of this referral must verify member eligibility on the date of service. The referral form does not take the place of a Prior Authorization (PA) nor should be used as a PA request.		
Date of Request:		
Member Information		
Name:	**DOB:**	**ID Number:**
Address:	**Contact Name:**	**Telephone:**
Referring Provider Information (Refer From) **(Provider who is initiating the referral)**		
Name of Referring Physician:		
Name of Person Completing Referral Form:		
Clinic/Office Address:		
Telephone Number:	**Fax Number:**	
Recipient of Referral (Refer To) **(Name of provider to whom the member is being referred)**		
Name of Recipient Provider:		
Clinic/Office Address:		
Telephone Number:	**Fax Number:**	
Date(s) of Service:		
Requested Service		
☐ **Evaluation/Consultation Only**	☐ **Evaluation and Treatment**	
Diagnosis:	☐ **Follow-Up Visit(s):**	
Clinical Summary Remarks: (Attach medical records for specialty referral, when necessary)		