

Important:

Primary Care Provider (PCP) Referral Authorization Form Completion Instructions

- **PCPs are encouraged to use the electronic Referral Authorization Form (RAF). It is quicker, easier, and less prone to mistakes that cause rejections.**
- RAFs must be written only for members who are assigned to the PCP during the month the RAF is written. Please check your case management list before issuing a RAF.
- If submitting a paper RAF, print must be legible. (Incomplete/illegible RAFs will be rejected.)
- Each RAF has a unique number and can only be used once.
- Please enter the requested effective dates. Changes to the dates are not allowed; another RAF must be issued.
- To restrict services, PCPs must mark the "Evaluation/Office Visit Only" box in the Description of Referred Services section.
- **PCPs must fax completed RAFs to CenCal Health at (805) 692-5140**

1 Primary Care Providers (PCP): This section will be preprinted with your practice's information. Please ensure that all the information is correct before completing the rest of the form.

2 Referral Provider: Enter the Referral Provider's information here. If the provider is part of a group, enter the group name where indicated. It is imperative that you provide the provider's phone number and NPI. If referring to a group, you may also indicate the individual in the space provided.

3 Member/Patient Information: Enter member's full name, date of birth, age, phone number, and ID number. To ensure the RAF is processed quickly, provide all relevant medical information. This includes the diagnosis codes, treatment orders, and symptoms.

4 Description of Referred Services: If you would like the referral provider to **TREAT AS MEDICALLY NECESSARY**, leave this area **BLANK**. If you wish to restrict services to consultations or office visits, please check the provided box.

5 Authorization Effective Dates: Enter the dates that you would like the RAF to be effective for. If only the "from" date is specified, if approved, the RAF will be valid for **3 months**.

6 Out of Area Referrals: If you are referring to a provider who resides outside of Santa Barbara or San Luis Obispo County, Section 2 – Out of Area Referrals must be completed. You must indicate if the member has been treated for the symptoms described in Section 1 and if so, by whom.

REFERRAL AUTHORIZATION FORM (RAF)
WEBSITE SUBMISSION

To submit these forms electronically, visit www.cencalhealth.org or call (805) 685-9525, ext. 1676 for more information.

SECTION 1 - To be completed by Primary Care Physician Only - PLEASE TYPE OR PRINT	
PRIMARY CARE PROVIDER	MEMBER (PATIENT) INFORMATION (Completed by PCP Only)
PCP Name (Group Name, if applicable) 1	Name
PCP's Address	Date of Birth Age Phone No. 3
Provider NPI (Group NPI, if applicable)	Member ID Number
Individual Physician Name (if part of Group)	Confirmed/Suspected Diagnosis Codes
Phone No.	Symptoms:
Contact Name Contact Phone No.	Duration of Symptoms:
I AM MAKING THIS REFERRAL WHILE "ON-CALL" FOR: PCP's Full Name Telephone:	
REFERRAL PROVIDER (Data Required)	
Name (Group Name, if applicable) 2	
Provider Street, City, State	
Provider NPI (Group NPI, if applicable)	
Individual Physician Name (if part of Group)	
Phone No.	
Contact Name Contact Phone No.	
DESCRIPTION OF REFERRED SERVICES	
To restrict services, please check below: 4	
<input type="checkbox"/> Evaluation /Office Visit Only	
<input type="checkbox"/> Transplant Evaluation Only	
REQUESTED EFFECTIVE DATES	
From _____ through _____ (date) 5	
Signature of Primary Care Provider or Authorized Representative 5	
X	
SECTION 2 - Out of Area Referrals	
Has the member received treatment for above described symptoms? If yes, with whom 6	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you attempted to refer this member to a provider within CenCal Health's service area? If yes, to whom 6	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
If not, why? 6	
Health Plan Remarks (for CenCal Health Use Only)	

Note: Authorization does not guarantee payment. Payment is subject to a patient's eligibility and other CenCal Health criteria. A RAF is only valid if it is completed in its entirety and written by the member's current Primary Care Provider (PCP) or one of the PCP's designated Call Group Associates. Inpatient care requires authorization from CenCal Health. By accepting this referral, the rendering provider hereby agrees to the following: they will only seek payment from CenCal Health, they will not balance bill the member or hold the member liable for any sums owed by CenCal Health, and they will resolve any disputes regarding payment with CenCal Health. The rendering provider also agrees to provide CenCal Health with access to all records relating to the health care services provided to CenCal Health members.

WHITE - PCP SUBMITS TO CenCal Health, At: Adjudication, 110 Castellon Drive, Goleta, CA 93117-3028, (805) 685-9525, (800) 421-2593;
PINK - PCP forwards to the Referral Provider, GREEN - PCP retains for their records

RAF 11/2009

Fax completed RAFs immediately to CenCal Health at (805) 692-5140
Pink triplicate should be forwarded to the Referral Provider; Green triplicate should be retained for the PCP's records

For Further Instructions on RAFs, refer to CenCal Health's Provider Manual located at www.cencalhealth.org. For questions, please contact Provider Services at (805) 562-1676