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Best Outcome for Every Patient Every Time

IOWA HEALTH SYSTEM EMPLOYER SPONSORED NETWORK OUT OF NETWORK REFERRAL REQUEST FORM

This form is to be used for members enrolled in the IHS Health Savings Plan or the IHS Network Plan (not required for members enrolled in the IHS High Deductible Plan). This form is to be completed by the IHS referring provider. Please type or clearly print this information.

Date Submitted: ____/____/____	
Patient Name: _____	Patient Date of Birth: ____/____/____
Member Name: _____	Member ID Number: _____
Member Employer (Affiliate): _____	
Referring Provider Information:	
Provider Name: _____	Provider NPI: _____
Address: _____	
Office Contact: _____	
Phone Number: (____) _____	Fax Number: (____) _____
Email: _____	
Specialty: _____	
Date of Diagnosis ____/____/____	
Diagnosis Code: _____	CPT/HCPC Code: _____
Description of Illness or Injury: _____	
History of Network Providers Seen: _____	
Services Requested (check all that apply): <input type="checkbox"/> Consult Only <input type="checkbox"/> Consult with Diagnostic Testing <input type="checkbox"/> Medical Treatment <input type="checkbox"/> Surgical Services	
<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Home Health <input type="checkbox"/> Hospice <input type="checkbox"/> Home Infusion <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Dialysis	
<input type="checkbox"/> Medical Equipment <input type="checkbox"/> Chiropractor <input type="checkbox"/> Facility	
Requested Duration Dates	From: ____/____/____ To: ____/____/____
Number of visits: _____	
Non-Network Provider Information:	
Name: _____	
Address: _____	
Phone Number: (____) _____	
Specialty: _____	
Reason for request. Please attach any clinical information to support the referral:	

Please return completed forms by fax to: 515-376-9092.

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