



ST. JOHN'S HEALTH SYSTEM, INC. REFERRAL FORM
PREMIER PLUS

FAX TO: St. John's Community Medical Management Fax # (417) 820-7866 or (800) 863-8040

Sender: _____ Date: _____ Time: _____

Phone: _____ Fax: _____ Pages: _____

If unable to fax, Mail to: St. John's Community Medical Management
3265 S. National, Suite 115
Springfield, MO 65807

Referral Number _____

Confidential - This confidential information belongs to the sender, which is legally or medically privileged information. If you have received this facsimile in error, please notify us at (417) 820-3182 or (800) 662-9962.

ITEMS REQUIRING SPECIAL APPROVAL

- Out-Of-Network
• Transplants Management
• PET Scans
• DME > \$500
• Changing Hearts
• New Images
• Prosthetics
• Specified Procedures*



Requires prior approval / pre-certification from St. John's Community Medical Management by faxing a completed Precert worksheet to (417) 820-7866 or (800) 863-8040. Or call at (417) 820-3182 or (800) 662-9962.
*Refer to Premier Health Plans Prior Authorization Precertification Guide. (See sample referral form)

NOTIFICATION NEEDS

- Urgent
 • Hospice*
 • Endstage Renal Disease (ESRD)*
 • Long Term (Custodial) Care*
 • Expiration of Member*



Requires notification by faxing to (417) 820-7866 or (800) 863-8040. Or call at (417) 820-3182 or (800) 662-9962.
*Use the Medicare Reporting Form.

Case management services available to assist in coordinating services and OP therapies. Phone at (417) 820-3182 or (800) 662-9962

PATIENT INFORMATION:

Form fields for Patient Last Name, Patient First Name, M.I., Date of Birth, Subscriber / Member ID Number, Employer or Group Number

REFERRAL INFORMATION:

Form fields for Referring Physician Last Name, Physician First Name, Physician M.I., Physician Telephone Number

REFER TO SPECIALIST / THERAPY / FACILITY:

Form fields for Full Name of Specialist / Therapy / Facility, Specialty, Address, Telephone Number

Appointment Date (If known): _____

Diagnosis or Reason for Referral: _____

Type of Referral: ✓ All that apply (if known)

- REC, Referral for consult only _____ visit(s)
 RET, Referral for consult and treatment _____ visit(s)
 Urgent Care
 Outpatient Facility
 Diagnostic Procedure (Specify) _____
 PET Scan
 OP Surgery Procedure (Specify) _____
 IP Admission
 Ambulance (Between facilities)
 Observation Admission
 Ancillary Service including:
 HHC (Specify Service) _____
 Physical Therapy
 Speech Therapy
 Home Infusion
 Occupational Therapy
 Orthotics
 Prosthetics or Therapeutic Shoes
 DME (> \$500 Rental or Purchase)

Valid for 30 Days 45 Days 60 Days 90 Days Other _____

Signature of person completing form _____ Phone # _____ Date: _____

PLEASE PRINT - REVIEW BACK OF FORM FOR ADDITIONAL CLAIM INFORMATION

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St. John's Community Medical Management
3265 S. National, Suite 115
Springfield, MO 65807

Send **CLAIM** to: Premier Benefits Inc.
P. O. Box 4568
Springfield, MO 65808

This Referral Form does not guarantee payment by Premier Health Plans. Responsibility for payment shall be subject to membership eligibility criteria, benefit limitations* under the applicable contract, and the interpretation of benefits under applicable subrogation and coordination-of-benefits rules, regulations and/or legislation. This referral is applicable only to the treatment as specified on front. For any service not specified, it will be necessary to obtain an additional referral authorization.

*For Premier Health Plans, examples of benefit limitations are: cosmetic surgery, orthotics, workers compensation, transportation, custodial care, experimental or investigational procedures, and personal comfort items. Contact member services at **(417) 837-0266** or **(800) 481-4466** for questions regarding benefit descriptions or refer to your member handbook and service agreement.

Referral type defaults: If not otherwise specified REC will be 3 visits and 60 days duration. The RET default will be unlimited visits in a 90 day period. The Inpatient Length Of Stay default is as deemed medically necessary.