Partnership HealthPlan of California
4665 Business Center Drive Fairfield,
CA 94534
(707) 863-4133 or (800) 863-4144
Fax: (707) 863-4118
PartnershipHP.org

Medi-Cal
Referral Authorization Form (RAF)

Member Name: _____

Date of Birth: _____

Member CIN: _____

Specialty Group Name: _____

Specialty Group NPI: _____

Address: _____

City, Zip: _____

Telephone: _____

**The consultant name must be the same as that used to bill for these services.*

TO BE COMPLETED BY THE PRIMARY CARE PROVIDER

Services requested:

☐ 12 mo. Consult / Continuing Care
Start Date: _____

☐ Other: From Date: _____ To Date: _____

If Non-Contracted provider, RAF must be approved by Partnership before given to member. Please provide H&P, progress notes, and evidence of exhaustion of Partnership's contracted, in-network specialists (i.e. denial letters, referral denials).

This referral is:

☐ Urgent (72 hours): potentially life-threatening condition.

☐ Routine (Up to 7 calendar days): important to health; not life-threatening.

Reason for referral:

☐ Member's preference
☐ Provider not accepting new patients
☐ Provider not available in network
☐ Specialized procedure / area of expertise
☐ Timely access to provider
☐ Other:

Provisional Diagnosis: _____

Current ICD code for primary Dx: _____

_____ _____

PCP Group Name: Group NPI:

_____ _____

Address City Phone Fax

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBLITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.