

Health Plan Referral Form

Note: Referral Form should be sent directly to the specialist you are referring to

Date of Request: _____

Insurance Information

Health Plan of Nevada: Commercial Medicaid

Other Insurance(s): _____

Member Information

Member Name: _____ Member ID Number: _____

Member Date of Birth: _____ Member Phone Number: _____

Member Address: _____

Referring Provider Information

Name: _____ Phone Number: _____

Contact Person (Name, Phone, and Fax): _____

Referral Information

Referring To (list provider or group name): _____

Specialty/Treatment Requested: _____

Reason for referral (please include diagnosis and any other applicable information):

*All sections of this form must be completed.

**Southern Nevada – please refer to Southern Nevada Referral Guidelines here for necessary testing and/or labs - <https://healthplanofnevada.com/Provider/Provider-Summary-Guide>

This referral is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's Evidence of Coverage, Certificate of Coverage, or Self Insured Employer's Plan Documents.

The information contained in this form, including attachments, is privileged and confidential & is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or the agent responsible to deliver to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.