



P I N A L • C O U N T Y
Wide open opportunity

PINAL/GILA LONG TERM CARE
 REQUEST FOR REFERRAL
OPTOMETRY/OPHTHALMOLOGY SERVICES
 PLEASE FAX ALL REQUESTS TO (520) 866-6717

Member Name: _____ ID# _____ DOB _____
 Medicare A B Other Insurance _____
 Name of Nursing Home/ALF _____
 EPSDT eligible member? Yes No CRS eligible member? Yes No
 Service Provider Number: _____
 (AHCCCS# of Provider referred to)
 Service Provider Name: _____
 (Name of Provider referred to)
Service Requested: _____
 Date of Service: _____ Appointment Time: _____
 Diagnosis Code: _____
 Requested CPT Code: _____ Est. Cost: _____

URGENCY STATUS: Standard (Based on members condition – Not to exceed 14 days)
 Expedited – Urgent (within 3 days)

Please answer the following questions for **ophthalmology** requests:

- For Cataract removal:
 - Is cataract visible by exam, ophthalmoscope or slit lamp? Yes No
 - Does member have decreased visual acuity attributed to cataract that cannot be corrected by lenses to better than 20/70? Yes No
 - If the posterior chamber cannot be visualized at all, has vision been confirmed by potential acuity meter (PAM) reading? Yes No
 - Is member's corrected visual acuity between 20/50 and 20/70? Yes No
- For all other ophthalmology referrals/vision acuity checks:
 - Disease process related to request: _____
 - Presenting problem to be evaluated: _____

Please answer the following questions for **optometry** requests:

- Date of Surgery _____
- Is the member 20 years of age or younger? Yes No
- Is this the first pair of glasses/lenses post cataract removal? Yes No

PCP/PCP Designee Signature _____
PHONE: _____ **FAX:** _____
 PCP Remember: It is your responsibility to assure a copy of this consult/treatment is present in your office/facility medical records

- Please attach the following: (Mandatory)**
- Copy of physicians order (if referral not signed by PCP)
 - Last History and Physical
 - Physician progress notes that support reason for referral and/or surgery.

***Standard Authorization Request:** A request for which P/GLTC provides a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request with a possible extension of up to 14 calendar days if the member or provider requests an extension of the P/GLTC establishes a need for additional information and delay is in the enrollee's best interest.
***Expedited authorization Request:** A request for which P/GLTC provides a decision to the member as expeditiously as the enrollee's health condition requires, but not later than three working days following the receipt of the authorization request with a possible extension of up to 14 days if the member or provider requests an extension or if P/GLTC establishes a need for additional information and delay is in the enrollee's best interest.

