



Pinal / Gila Long Term Care

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

Member Name: _____		ID# _____	DOB _____
Medicare A <input type="checkbox"/>	B <input type="checkbox"/>	Other Insurance _____	
Name of Nursing Home/ALF _____			
EPSDT eligible member? Yes <input type="checkbox"/> No <input type="checkbox"/>		CRS eligible member? Yes <input type="checkbox"/> No <input type="checkbox"/>	
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: <input type="checkbox"/> Standard (Based on members condition-Not to exceed 14 days)			
<input type="checkbox"/> Expedited-Urgent (within 3 days)			
Please indicate if Member has any of the following systemic conditions: (Check all that apply to Member)			
<input type="checkbox"/> Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)	<input type="checkbox"/> Buerger's disease (thromboangilitis obliterans)	<input type="checkbox"/> Chronic thrombophlebitis	<input type="checkbox"/> Diabetes mellitus
<input type="checkbox"/> Hereditary disorder, i.e., hereditary sensory radicular neuropathy, Fabry's disease	<input type="checkbox"/> Leprosy or neurosyphilis	<input type="checkbox"/> Malabsorption Syndrome	<input type="checkbox"/> Multiple Sclerosis
		<input type="checkbox"/> Peripheral neuropathies involving the feet	<input type="checkbox"/> Pernicious Anemia
		<input type="checkbox"/> Traumatic injury	<input type="checkbox"/> Uremia (chronic renal disease)
		<input type="checkbox"/> Other _____	
Is there clinical evidence of mycosis of the toenail? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>			
If member is ambulatory, do mycotic toenails interfere with ambulation? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>			
If member is non-ambulatory, does member have a condition that is likely to result in significant medical complications in the absence of treatment for mycotic toenails or other routine foot care? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>			
If yes, Explain _____			
For bunionectomy, please answer the following questions:			
Is there an overlying skin ulceration present? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Is there a neuroma secondary to bunion? Yes <input type="checkbox"/> No <input type="checkbox"/>			
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 the physician order (if referral not signed by PCP)			
Most recent history and physical, physician progress notes that document systemic condition.			
PLEASE NOTE THE FOLLOWING BEFORE SUBMITTING REFERRAL:			
Members with Medicare as their primary insurance receiving Medicare covered podiatry services WILL NOT require prior authorization			
Members with Medicare as their primary insurance receiving non-Medicare covered podiatry services WILL require prior authorization			
Member with P/GLTC as their primary insurance receiving any podiatry services WILL require prior authorization.			

*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.