Referral Authorization Form (RAF)

Referring Clinician Affiliation (check one)

Primary Care

- ❑ San Mateo Coastside Clinic NPI: 1720261464
- ❑ Daly City Clinic NPI: 1255400909
- ❑ Fair Oaks Clinic NPI: 1871529073
- ❑ South San Francisco Clinic NPI: 1609812148
- ❑ Willow Clinic NPI: 1336239052
- ❑ San Mateo Medical Center
  - __ INPT
  - __ OP
  - __ ER
- ❑ Ravenswood / Belle Haven NPI: 1821170044

Specialty

- ❑ Innovative Care 39th Avenue Clinic ID#: GR0028880
- ❑ Specialty Clinic ____________
- ❑ Ron Robinson

Information about Patient

Patient Name:

SMMC Patient Medical Record Number:

SMMC Patient Account Number:

Outside Provider Information

Provider / Vendor / Specialist: ____________

NPI Number(s): ____________

Address: ____________

____

Phone Number: ____________

Fax Number: ____________

Patient Information

Address: ____________

____

Phone Number: ____________

Date of Birth: ____________

HPSM / MCE Participant ID #: ____________

Physician Request

Diagnosis: ____________ ICD-9 Code(s) (Mandatory): ____________

Reason for Outside Referral: (Attach clinical information) ____________

Treatment or Service Requested: ____________

Type of Referral (check one): ❑ Consultation only ❑ Consult and Treat ❑ Other services or supplies:

Phone Number: ____________ Requesting Physician Name: ____________

Fax Number: ____________ Signature: ____________ Date: ____________

Note: Please forward consultation notes under separate cover to referral providers.

Instructions

For Referring Provider

1) Please complete this form, and fax it to the Health Plan of San Mateo (HPSM) at 650-829-2079. URGENT FAX: 650-829-2021
2) Incomplete or illegible forms will be returned.
3) Once the referral is approved, give a copy of this form to the patient to make an appointment with the Specialty or Out of Network Provider.
4) For questions on this request, please call HPSM Health Services at 650-616-2070.

For Provider of Service / Referral Provider

1) HPSM is contracted to process authorizations and claims on behalf of San Mateo Medical Center (SMMC). Final payment will be issued by SMMC.
2) This RAF is only valid for 90 days from receipt at HPSM for initial consult.
3) If you believe additional services are required, please contact the referring provider to develop a treatment plan. The referring provider must submit a new referral request to HPSM for the additional services to be covered.
4) Some services require prior authorization. Contact HPSM for more information on submitting a Treatment Authorization Request at 650-616-2070.
5) Authorization does not guarantee payment. Payment is subject to patient's eligibility. Be sure the ID card is current before rendering service.
6) Submit claim within 30 days to: Health Plan of San Mateo, 701 Gateway Blvd., Suite 400, South San Francisco, CA 94080.

Authorization Information

Authorized Dates of Service: ____________ Authorization Number: ____________

Comments: ____________

____

Signature: ____________ Date: ____________

Outside provider acceptance of the referral and provision of services thereof constitutes agreement to all San Mateo County terms and provisions of payment. Moreover, by acceptance of this referral, outside provider agrees to hold harmless and indemnify San Mateo County for all losses, claims, damages, injuries, illnesses, or death to patient due to the negligence of outside provider. Reimbursement for payment made will be expected if patient is granted Medi-Cal retroactively within 30 days of notification to outside provider.