



**Direct Referral Request
No Authorization Required**

- 1) Check member's eligibility at time of service.
- 2) Direct patient with a copy of the referral to a network facility contracted with Exclusive Care. Please see our web page for a listing of providers; www.exclusivecare.com
- 3) Fax to the requested provider and to Medical Management (951) 955-0035
- 4) For further assistance please call us at 1-800-962-1133 option 3

Patient Name: _____ Phone # _____

DOB: _____ Member ID #: _____ Date: _____

Diagnosis: _____

Provider: _____ Phone #: _____ Fax #: _____

| Routine | Radiology/Diagnostic | Radiology/Diagnostic |
|---|--|--|
| <input type="checkbox"/> Colonoscopy - 50 and older Consult, procedure and Follow up <input type="checkbox"/> DM Annual Eye Exam or Retinal Camera Screening <input type="checkbox"/> Family Planning - Birth Control, Tubal Ligation, Vasectomy (Operating Room requires prior auth.) <input type="checkbox"/> Global OB Care <input type="checkbox"/> GYN Annual -1 st visit only <input type="checkbox"/> TAB -up to 24 weeks Planned Parenthood only <input type="checkbox"/> EAP (Behavioral Health) – Patient Calls Directly Riverside Area – 951-778-3970 Desert Area - 760-328-6863 <input type="checkbox"/> Health Education Programs Asthma Education – 951-358-4977 Breast Feeding Support – 951-358-5311 Child Safety Seat Program – 800-455-4942 Childbirth Preparation – 951-486-5195 Diabetic Education – 800-720-9553 Healthy Choice Smoking Cessation – 951-358-4977 Sweet Success -DM Pregnancy – 951- 720-9553 Medical Nutrition Therapy – 800-720-9553 Request a pamphlet – 800-962-1133 option 1 | <input type="checkbox"/> Barium Enema <input type="checkbox"/> Chest X-ray <input type="checkbox"/> EKG <input type="checkbox"/> EEG <input type="checkbox"/> IVP <input type="checkbox"/> KUB <input type="checkbox"/> Total Fracture Care | <input type="checkbox"/> Mammogram - annual 40 and over <input type="checkbox"/> Mammogram –Follow up after abnormal results <input type="checkbox"/> Pulmonary Function Study <input type="checkbox"/> Skeletal X-ray <input type="checkbox"/> Upper GI <input type="checkbox"/> Ultrasound <input type="checkbox"/> Dexa Scan |

Referring PCP: _____
(Please print name) (Signature)

Phone#: _____ Fax#: _____

