MEDICALLY NEEDY SHARE OF COST/ POLK HEALTHCARE PLAN

Authorizations Telephone #'s:
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MEDICALLY NEEDY SOC REFERRAL REQUEST

TODAY'S DATE:

MEMBER INFORMATION (Medically Needy Share of Cost Member)	
Name:	**Address:**
DOB:	**City/State/Zip:**
Member ID:	**Telephone:**

Service Requested
CPT:
ICD-9:
FACILITY:

PROVIDER INFORMATION			
Referred From:		***Referred To:***	
(CHECK APPROPRIATE BOX) ☐ **PCP** ☐ **Specialist** *(NAME OF PCP OR SPECIALIST)*		**Provider Name:**	
Contact Person:		**Specialty:**	
Address:		**Address:**	
City/State/Zip:		**City/State/Zip:**	
Tel:	**Fax:**	**Tel:**	**Fax:**

****All requests must be accompanied by medical records that demonstrate the medical necessity for the referral****

Reminder: All medically necessary labs should be sent to LabCorp

Org. 9/2000 Rev. 6/2001, 1/2002, 5/2005, 11/2009, 12/2011