



Fallon Community Health Plan
 10 Chestnut Street
 Post Office Box 15121
 Worcester, MA 01615-0121

Plan Determination

REFERRAL NO.		TODAY'S DATE		SCHEDULED APPOINTMENT DATE		
PATIENT INFORMATION	PATIENT NAME		D.O.B.			
	INSURANCE NUMBER		MRN			
	GUARANTOR					
	ADDRESS					
	CITY, STATE, ZIP					
	HOME TELEPHONE					
	WORK TELEPHONE					
CARE AND SERVICES	OFFICE VISIT		ER	MENTAL HEALTH	PHARMACY	SPECIAL
	STATUS		EXTENT OF SERVICE		NUMBER OF AUTHORIZED VISITS	
	APPROVED <input type="checkbox"/>	DEIED <input type="checkbox"/>	FROM	TO		
REFERRAL TYPE						
REQUESTING PHYSICIAN AND PRIMARY PHYSICIAN	REFERRED BY		REFERRED TO			
	PRIMARY MD		DIAGNOSIS			
	PRIMARY MD SITE					
REFERRAL NOTES						
REFERRED TO PROVIDER INFORMATION	TELEPHONE NUMBER			PROVIDER'S RESPONSIBILITY Failure to adhere to the following guidelines may result in patient liability Only services authorized by this form will be paid by the Fallon Community Health Plan. Additional services, referral to another consultant or hospitalization by a non-Fallon physician requires further authorization. Any x-rays, laboratory tests or other services must be done within the Fallon Healthcare System. A referral request must be submitted for services not available within the Fallon Healthcare System.		
	ADDRESS					

Sample

MAIL TO PROVIDER