



810 Main Avenue S.
Rugby, ND 58368
701-776-5848
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REFERRAL REQUEST

Referring Dept. HAMC ___ HAMC-JC ___ Satellite ___ St. Andrews ___ Other ___

Patient Name _____ DOB _____ HAHP ID# _____

Patient Address (Street, City, State, Zip) _____ Phone (Home and Work) _____ Primary Care Physician _____

Referred to (Physician Name) _____ Address (City, State, ZIP) _____

Diagnosis: _____

Number of visits requested: _____ Appointment Date: _____

Care Request: (Please indicate level of care)

- _____ Consultation = A request for an opinion only (one visit)
- _____ Treatment = A request for diagnostic evaluation and treatment
- _____ Follow-up = A request for opinion and further treatment if medically indicated
- _____ Surgery = A request for consultation, surgery, and follow-up
- _____ Other _____

Reason for Referral Request Out-Of-Network

- _____ Service not available at HAMC or contracting facilities
- _____ Emergency/Urgent Services
- _____ Patient Request
- _____ Continuity of Care

Primary Care Provider Signature _____

Date of Referral _____

Important Notes: Referral is valid for **six (6) months** from the above date. A report must be submitted to physician before reimbursement will be made. Also, failure to pre-authorize additional visits or services will result in denial of payment.

TO BE COMPLETED BY HAHP

- _____ Referral Approved
- _____ Referral Denied
- _____ Needs More Information

COMMENTS:

Number of Visits Approved: _____

HAHP MEDICAL DIRECTOR _____

DATE _____