

## Sample Referral & Authorization Form (SPC 0000)

Member Information						
	400 Lan - 100-100 April					
Name (Last First, MI)  Date of Birth		Phone Number				
Smith, John M	08-22-1966	Busi	ness (608) 555-6796			
Address						
1234 Any Street, Eau Claire WI 54701						
Pets in Home: Small Dog (Rusty) Smoker in Home: Yes No Allergies (list):		Others in Home:				
Penicillin		Cuardian/Activ	rated Dower of		A 130000 -	
Emergency Contact Name (Last, First, MI)	First, Phone:		Guardian/Activated Power of Attorney For Healthcare Name		Phone:	
Smith, James	Home: (608) 555-6774	(Last, First, MI)				
Smith, Gail	Smith, Gail	POAH: Smith, (	Gail	Но	me: (608) 555-677	4
Clinical Information						
Hospital of Choice:  Example Hospital Name	Primary Physician: Dr. Smith		Psychiatrist: <b>Dr. Jones</b>			
Related Diagnosis/Symptoms:			L			
Example Text						
Additional Information (Special Instructions/Safety):						
Example Text						
Authorization Information  Date of Referral				New Referral	☐ Updated R	eferral
05/05/2017				i wew nerenar	opaatea :	cremui
Vendor Number Provider	Name	Authorization Comments:				
123456 Example	Provider Name	Example authorization com	ments			
123456 Example SPC	Provider Name	Service Start Date	Service End Date	Units	Frequency	
SPC	Provider Name	Service Start Date	Service End Date	Units		
SPC  000.00 Service Description	Provider Name	Service Start Date  MM/DD/YYYY	Service End		Frequency  Monthly  Weekly	
SPC  000.00 Service Description  000.01 Service Description	Provider Name	Service Start Date  MM/DD/YYYY  MM/DD/YYYY	Service End Date  MM/DD/YYYY  MM/DD/YYYY	1 2	Monthly Weekly	
SPC  000.00 Service Description	Provider Name	Service Start Date  MM/DD/YYYY	Service End Date MM/DD/YYYY	1	Monthly	
SPC  000.00 Service Description  000.01 Service Description  000.02 Service Description  Inclusa Community Resource Coordinator		Service Start Date  MM/DD/YYYY  MM/DD/YYYY  MM/DD/YYYY	Service End Date  MM/DD/YYYY  MM/DD/YYYY  MM/DD/YYYY	1 2 3	Monthly Weekly Yearly	
SPC  000.00 Service Description  000.01 Service Description  000.02 Service Description  Inclusa Community Resource Coordinator Name (Last, First)	e	Service Start Date  MM/DD/YYYY  MM/DD/YYYY  MM/DD/YYYY  MM/DD/YYYY	Service End Date  MM/DD/YYYY  MM/DD/YYYY  MM/DD/YYYY  MM/DD/YYYY  usa Health& Wellnesne (Last, First)	1 2 3	Monthly Weekly Yearly Phone	44
O00.00 Service Description O00.01 Service Description O00.02 Service Description Inclusa Community Resource Coordinator Name (Last, First) Phone Smith, Judy (715)	e 555-1234	Service Start Date  MM/DD/YYYY  MM/DD/YYYY  MM/DD/YYYY  MM/DD/YYYY	Service End Date  MM/DD/YYYY  MM/DD/YYYY  MM/DD/YYYY	1 2 3	Monthly Weekly Yearly	14
O00.00 Service Description O00.01 Service Description O00.02 Service Description  Inclusa Community Resource Coordinator Name (Last, First) Phone Smith, Judy (715)! Reason For Referral (Identified Goal.Outcome):	e 5555-1234 Example Text	Service Start Date  MM/DD/YYYY  MM/DD/YYYY  MM/DD/YYYY  MM/DD/YYYY	Service End Date  MM/DD/YYYY  MM/DD/YYYY  MM/DD/YYYY  MM/DD/YYYY  usa Health& Wellnesne (Last, First)	1 2 3	Monthly Weekly Yearly Phone	4
O00.00 Service Description O00.01 Service Description O00.02 Service Description  Inclusa Community Resource Coordinator Name (Last, First) Phone Smith, Judy (715):  Reason For Referral (Identified Goal Outcome): Referral Comments (Special Instructions/Safety)	e 5555-1234 Example Text	Service Start Date  MM/DD/YYYY  MM/DD/YYYY  MM/DD/YYYY  MM/DD/YYYY	Service End Date  MM/DD/YYYY  MM/DD/YYYY  MM/DD/YYYY  MM/DD/YYYY  usa Health& Wellnesne (Last, First)	1 2 3	Monthly Weekly Yearly Phone	14
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