Ho-Chunk Nation
ALHM Referral Form

CHECK IF URGENT: ☐ CONFIDENTIAL FAX# 715-284-0100

Refer to (Name, Address, Phone):	Appt Date: _____ Appt Time: _____ ☐ Inpatient ☐ Outpatient	Primary Payer: ☐ Employee ☐ Medicare ☐ Medicaid ☐ Private ☐ Patient ☐ VA ☐ Other _____

Reason for Referral: _____

_____

Supportive Diagnostic/Procedural/Medical Hx: _____

_____

Number of visits requested: _____

Priority Level: _____

1 - LEVEL I. EMERGENT/ACUTELY URGENT CARE SERVICES
DEFINITION: Diagnostic/therapeutic services that are necessary to prevent the immediate death/serious impairment of the health of the individual, and if left untreated, would result in uncertain but potentially grave outcomes.
2 - LEVEL II. PREVENTIVE CARE SERVICES
DEFINITION: Primary health care that is aimed at the prevention of disease/disability such as, non-urgent preventive ambulatory care, screening for known disease entities, and public health intervention, etc.

3 - LEVEL III. PRIMARY AND SECONDARY CARE SERVICES
DEFINITION: Inpatient and outpatient care services that involve the treatment of prevalent illnesses/conditions that have a significant impact on morbidity and mortality.
4 - LEVEL IV. CHRONIC TERTIARY AND EXTENDED CARE SERVICES
DEFINITION: Inpatient and outpatient care services that (1) are not essential for initial/emergent diagnosis/therapy, (2) have less impact on mortality that morbidity, or (3) are high cost, elective, and often require tertiary care facilities.
5 - LEVEL V. EXCLUDED SERVICES
DEFINITION: Services and procedures that are considered purely cosmetic in nature, experimental or investigational, or have no proven medical benefit.

CPT Procedure Category (see page 2): _____

ICD Diagnostic Category (see page 2): _____

Patient MRN: _____

Name: _____

Address: _____

_____

Phone: _____

Referring Provider (print): _____

_____
Signature Date

MCC Signature Date

☐ Issue Purchase Order
☐ Referral Denied
☐ Referral Deferred
☐ Unmet Need

MCC Comments/Recommendations: _____

_____

_____

FOR REFERENCE ONLY

DO NOT FAX OR SUBMIT THIS PAGE

CPT Procedure Category: (enter corresponding number on page 1)

1. Diagnostic Imaging
2. Evaluation and/or Management
3. Nonsurgical Procedures
4. Operations/Surgery
5. Pathology and Laboratory
6. Other:

ICD DIAGNOSTIC CATEGORY (enter corresponding number on page 1)

1. Cardiovascular Disorders
2. Cerebrovascular Disorders
3. Congenital Anomalies
4. Dental and Oral Surgical Disorders
5. Dermatologic Disorders
7. Endocrine, Nutritional, Metabolic, and Immunological Disorders
8. Female Breast and Genital Tract Disorders
9. Gastrointestinal Disorders
10. Hematological Disorders
11. Infectious and Parasitic Diseases
12. Injuries and Poisonings
13. Male Genital Organ Disorders
14. Mental Disorders
15. Musculoskeletal and Connective Tissue Disorders
17. Nephrological and Urological Disorders (kidney, ureter, bladder, and urethra)
18. Neurological Disorders
19. Obstetrical Care
20. Ophthalmological Disorders
21. Other Perinatal Conditions
22. Other Symptoms, Signs, and Ill-Defined Conditions
23. Other Vascular Disorders
24. Otolaryngological Disorders
25. Preventive Health Care (immunizations, well child care, etc)
26. Respiratory Disorders

ATTENTION

SCHEDULE APPOINTMENT(S) IN ADVANCE FOR PRIORITY LEVEL I ONLY

PLEASE DO NOT SEND COVER SHEET WHEN FAXING ONLY 1 REFERRAL

DO NOT SEND MEDICAL RECORDS OR SUPPORTIVE DOCUMENTS TO CHS

PLEASE SUBMIT TO MED RECORDS

THANK YOU