



Ho-Chunk Nation ALHM Referral Form

CHECK IF URGENT:

CONFIDENTIAL FAX# 715-284-0100

Refer to (Name, Address, Phone): _____ _____ _____	Appt Date: _____	Primary Payer: <input type="checkbox"/> Employee <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> Patient <input type="checkbox"/> VA <input type="checkbox"/> Other _____
	Appt Time: _____	
<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient		

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