NETWORK MEDICAL MANAGEMENT, MSO | ALL AMERICAN MEDICAL GROUP

AAMG
All American Medical Group

NETWORK MEDICAL MANAGEMENT

FAX NUMBER

Routine: (415) 390-6754

Urgent: (415) 663-5197

REFERRAL REQUESTED DATE:_____

CIRCLE ONE:

Medicare	Commercial/Medi-Cal
ROUTINE	ROUTINE
(14 Calendar days)	(5 Business days)

All Lines of business:

URGENT	RETRO
(Up to 72 Hours)	(Up to 30 days)

DATE OF SERVICE:_____

FORM WILL BE RETURNED IF MEMBER'S NAME, ID#, HEALTH PLAN or/and CLINICAL INFORMATION ARE NOT COMPLETE OR NOT LEGIBLE

PATIENT INFORMATION:

Patient Name: Last _____ **First** _____ **Middle** _____ **DOB** _____/_____/_____ **AGE** ____ **Sex**: (M) (F)

Address: _____ **City:** _____ **Zip** _____ **Phone #** ( ) _____ - _____

Health Plan _____ **Member ID #**_____ **Member Effective Date** _____/_____/_____

PCP _____ **Phone #** ( ) _____ - _____ **Fax** ( ) _____ - _____

Referring Provider Name :_____

M.D. Office Contact Name:_____

Phone: (_____**)**_____**-**_____ **Fax: (**_____**)**_____**-**_____

Referred to Specialty:_____

Provider Name:_____

Phone: (_____**)**_____**-**_____ **Fax: (**_____**)**_____**-**_____

Services to be provided at: Office = 11, Inpatient Stay = 21, Outpatient Hospital = 22 **REQUESTED FACILITY:**_____

DIRECT REFERRALS ONLY: (*CHECK ONE*) **ANY FOLLOW VISITS OR PROCEDURES MUST BE PRE-AUTHORIZED BY NMM**

Well Woman Exam **(New Patient):** ☐**99385 (age 18-39)** ☐**99386 (age 40-64)** ☐**99387 (age 65+)**
(Est. Patient): ☐**99395 (age 18-39)** ☐**99396 (age 40-64)** ☐**99397 (age 65+)** | ☐**Pregnant OB Care (full term) - 59400**

☐ **Chest, Long Bone KUB X- Rays** ☐ **Mammography: 77067 (Age 40 and older eligible every 2 years)**

☐ **PATIENT REQUEST** ☐ **M.D. REQUEST**

Diagnosis: _____ **ICD-10 code (s)**_____

Requested Services/Treatments

Procedure description:_____ **CPT CODE** _____

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Clinical Problem & Duration:_____

_____

Pertinent Clinical History / Lab / X-Ray:_____

_____

Treatment tried/failed:_____

Why is this referral or test (s) necessary? _____

PHYSICIAN SIGNATURE:_____ **DATE:** _____

STATEMENT FOR PROVIDER: **Further care must be authorized before it is rendered**. If additional treatment is required contact the referring physician. Additionally, consultant's findings and recommendations **must** be sent to the referring physician.
Authorization does not guarantee payments: All claims are subject to Eligibility, Contracted provisions and Exclusions. This certificate is good for 60 days from approval day. All Lab work and Imaging studies should be done at a Network Medical Management contracted facility.
UM decisions are based on standardized criteria. Provider may view criteria upon request. Call 415-216-0088 for more information.

Effective Date: 03/01/2023