CORIZON HEALTH

Authorization #:

Consultation Request

(Note: Always send with UM1100 - Consultation Report and Instruction to Provider)

Inmate:	Inmate #:	Date of Birth:	Sex: ○ Male ○ Female
Site:	Phone:	Fax:	Cost center:
Date of Request:		DOI:	EDR:
○ Off-site ○ On-site clinic ○ Telemedicine		○ Urgent ○ Routine ○ Retro request	
Responible Party: ○ Corizon ○ Health Insurance ○ Auto Insurance ○ Other:			
Service Type Requested complete additional applicable fields : ○ Office Visit (OV) ○ X-Ray (XR) ○ Scheduled Admission (SA) ○ Outpatient Surgery (OS) ○ OptionButton19			
Mulitple Visit Treatments: ○ Radiation Therapy ○ Chemotherapy ○ Other:			Number of Visits/Treatments:
Provider:	Initial visit or F/U:		F/U#:
Presumed diagnosis:			
Describe signs and symptoms:			
Date of Onset:			
Exam Data/Objective Findings:			
Lab & X-ray data:			
Current medications:			
Failed outpatient therapies:			
Enrolled in Chronic Care Clinic: ○ Yes ○ No	Which Clinic(s):		
Other diagnosis:			
Comments:			
☐ Proceed with requested service as described above ☐ Alternative Treatment Plan (ATP) for consideration (see below)			
RMD Signature:		Date:	
Site Medical Provider:	Signature:	Date:	
Site Medical Director:	Signature	Date:	
UM Nurse Reviewer/Regional Medical Director:	☐ Proceed with requested service as described above by site director ☐ Alternative Treatment Plan for consideration as described by the RMD		
Comments:			
Initials:	Date:		

Note: Notify physician or midlevel practitioner immediately if unable to obtain appointment within 4 weeks. If service is not completed within 4 weeks, have patient evaluated by practitioner or midlevel practitioner to determine service is still necessary and appropriate.

AN ATP OF ANOTHER SERVICE HAS BEEN RECOMMENDED BY THE RMD A NEW REFERRAL (401) NEEDS TO BE GENERATED FOR THIS SERVICE BY E SITE PROVIDER AND SENT TO THE UM REVIEWER. FOR ATP OF SITE PROVIDER FOLLOW-UP, NEW REFERRAL IS NOT INDICATED.

M1101