Primary Care Provider Referral Form

Referral Policy

The NHI Primary Care Provider (PCP) is responsible for guiding the care of the NHI beneficiary. Access to rehabilitative therapies, home health services, secondary and tertiary care requires a referral from the primary care provider. Referrals do not need pre-authorization from NHI but all overseas care and some services provided on island require pre-authorization in addition to a primary care referral (see pre-authorization policy and benefit schedule). Providers will not bill beneficiaries for a service requiring preauthorization if the authorization was not obtained or was denied unless the provider has written consent from the beneficiary to proceed with obtaining the service and the beneficiary is aware that the service is not covered by NHI and that they will be responsible for payment.

Send completed referral form to NHI:

494-6022 (Fax #) or NHIClinical@vinhi.vg (Email)

Provider Information

Primary Care Provider (PCP):		Date:	
Contact Person at PCP Office:		PCP Phone:	
PCP Office Address :		PCP Fax:	
Provider beneficiary is being referred to:		Provider's Specialty:	
Provider's address:		Provider's Phone:	
New Referral or Update?		Provider's Fax:	
Referral Date Span/ Start Date		Referral Date Span/ Stop Date (not to exceed 6 months)	

Beneficiary Information

Beneficiary's Name: _____

Beneficiary's Date of Birth: _____

Beneficiary's NHI ID# _____

Beneficiary's Address & Phone Number: _____

Reason for Referral:

_____

Provider Certification: I hereby attest that the services for which this [referral/submission for pre-authorization] is made (i) are appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition; (ii) provide for the diagnosis or the direct care and treatment of a medical condition; and (iii) are not primarily for the convenience of the Beneficiary, and Beneficiary's attending or consulting physician, or another health care provider.

_____

Provider Signature & Date

For NHI Use Only

Date Received: _____ Date entered : _____

Staff Member: _____ _____

Save **Print** **Submit**