



DATE ISSUED: \_\_\_\_\_

**All Referrals Must Be Made to: Children First Medical Group (CMFG) Contracted Providers**

- Routine lab and X-ray services DO NOT require a referral form.
- **This form is for services that DO NOT require prior authorization.** Please refer to the CFMG Prior Authorization list. All surgical procedures require prior authorization from CFMG’s Utilization Management Department.
- Services requested on this referral form should be initiated within 60 days of the issue date indicated above and expire in six months.
- The specialist is required to send a report to the PCP regarding findings, treatment and recommendations.

Patient Name:	DOB: _____	ID#
Name of Specialist Referred to:	Type of Specialty:	
Address of Specialist:	<b>Appointment # / SPC Phone #:</b>	
	SPC Fax #:	
Name of Referring PCP:	PCP Phone #:	
Signature of Referring PCP:	PCP Fax #:	
Diagnosis/Reason for Referral:		

**CHECK TYPE OF SERVICE TO BE PROVIDED**

- Initial consultation and report (1 visit).
- Initial consultation and report with follow-up for a total of \_\_\_\_\_ visits (no more than 3).
- Ongoing care (e.g., allergy) for \_\_\_\_\_ visits over the next \_\_\_\_\_ months (up to 12).
- Special procedure, test or treatment as indicated or per Referral Guideline.

**Paper Claims**

Children First Medical Group, Inc.  
 PO Box 99680  
 Emeryville CA 94622

**EDI Claims**

Children First Medical Group  
 Payer #: 94321

- All laboratory and X-ray studies must be performed by a contracting provider.
- Referrals to non-contracting providers require prior authorization from CFMG.
- Coverage is based on eligibility at time service is provided and within benefit limitation.

**For services that require Prior Authorization contact:  
 CHILDREN FIRST MEDICAL GROUP UTILIZATION MANAGEMENT  
 9:00am to 5:00pm Monday-Friday**

TELEPHONE: 510-428-3489

FAX: 510-450-5868