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Patient Identification, Address, Phone

Patient Name: JOHN DOE
SSN: 123456789
Address: PO BOX 123
TOWN, SD 12345

ID Number: AA 12345
Sex: MALE
DOB: 01/01/1999
Hm Phone: (605) 123-4567

Referred to: ACME MEDICAL CENTER (800-123-4567)
(JOHN SMITH, MD)
Mailing: PO BOX ABC
TOWN, SD 98765

Physical: 999 S HIGHWAY 22
OTHER TOWN, SD 45678
XXXXXXXXXX **(IHS Ref#)**

OUTPATIENT Services
# of Outpatient Visits: 1
Priority Rating: 2

Appointment Date: 07/01/18
Expected Ending Date:

Purpose/Services Requested: ORTHOPEDIC SURGERY CONSULT – R KNEE

THIS SECTION MAY INCLUDE MORE INFORMATION (SUMMARY OF REFERRAL)
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Additional Medical Information Attached: NO

If you have any questions concerning this referral, please contact:

IHS FACILITY NAME (contact: PURCHASED REFERRED CARE))
PO BOX ABC
TOWN, SOUTH DAKOTA 12345 (phone: (605) 123-46789)

Referring Provider (ELECTRONIC SIGNATURE): REFERRING IHS PROVIDER NAME HERE
NPI: 123456789
Case Manager: IHS CASE MANAGER NAME HERE

Veteran: NO

Records indicate patient has no third party coverage for this Service Date.

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THIS IS A MEDICAL REFERRAL. PURCHASE REFERRED CARE (PRC) FORMERLY KNOWN AS CONTRACT HEALTH SERVICES HAS **APPROVED** THIS REFERRAL. THIS REFERRAL IS AUTHORIZD ONLY FOR THE SERVICE(S) SPECIFIED. SUBSEQUENT VISITS, TESTS, OR PROCEDURES REQUIRE ADDITIONAL APPROVAL. PLEASE BILL THE PATIENT'S PRIMARY MEDICAL COVERAGE, THEN INDIAN HEALTH SERVICE, XXXXXXXX HEALTH CARE CENTER WHOM WILL BE RESPONSIBLE FOR THE BALANCE AND DEDUCTIBLE (IF APPLICABLE). SHOULD THE PATIENT'S PRIMARY COVERAGE DENY PAYMENT, PLEASE SUMBIT THE DENIAL LETTER TO THE IHS. MEDICAL DOCUMENTATION IS REQUIRED FOR ALL SERVICES PROVIDED. PLEASE SUBMIT VIA MAIL OR BY FAX TO (605) 123-5678. ATTENTION: XXXXXXXX HEALTH INFORMATION MANAGEMENT DEPARTMENT. THANK YOU.

(NOTE: This information may vary depending on the IHS facility)

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Contract Health Service Office