CONSULT VERIFICATION FORM

Complete this form prior to seeking specialist care services.

Mail form to: **DocFirst/Primary Select**
c/o LBA HealthPlans
9475 Deereco Road, #408
Timonium, MD 21093

Fax form to:
(410) 427-3699

All questions should be directed to our Customer Care Center at: (800) 793-9403 DocFirst, (800) 815-8240 Primary Select

*Valid for 90 days from Consult Verification date.
(This Consult Verification Form can be valid for up to 1 year at the discretion of the physician.)

PATIENT INFORMATION (COMPLETED BY EMPLOYEE/INSURED)

Patient Name: ______________________ **Patient Date of Birth:** __________

Employee Name: ______________ **SSN:** __________ **Employer:** __________

Full Name of Family Doctor: ______________________

Family Doctor Address: ______________________

Family Doctor Phone Number: ______________________

CONSULT INFORMATION (COMPLETED BY FAMILY DOCTOR)

Consult Verification (Referral) Date: __________ * **Consult Verification (Referral) Expiration Date:** __________

Provider/Group Name: ______________________

Provider/Group Tax ID: ______________________

Institution Name: ______________________

Address: ______________________ **State:** __________ **Zip:** __________

Phone Number: ______________________

Diagnosis/Condition: ______________________ **ICD-9:** __________

Service:
- ☐ **Consultation (description)** ______________________
- ☐ **Surgery**
- ☐ **Inpatient Hospital**
- ☐ **Global OB/GYN and Delivery**
- ☐ **Other** ______________________

Family Doctor Signature ______________________ **Date** __________

Family Doctor Tax ID # ______________________

Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan/carrier.
(It is not necessary to forward a copy of this referral form to your specialist.)

LBA 103-888

White: Send (Fax) to DocFirst/Primary Select Yellow: Family Doctor copy Pink: Member copy