Primary Care Provider (PCP) Referral Form

Both PCPs and Specialty Providers should review the Sonder ***Service-Specific Referral Not Required List*** *to identify what specialty services are able to render under a PCP's initial referral to a Specialty Provider; all other services require that Specialty Providers follow-up with Member's PCP to review Member's visit/progress notes and determine what Service-Specific Referral, if any, will be required to meet Member care needs.* PCPs must fax the completed PCP Referral Form to **(888) 217-4320** to notify Sonder Health Plans that they have referred Member for specific specialty services. Sonder Health Plans may reach out to the PCP to obtain additional information and discuss updates to Member's Individual Care Plan (ICP) regarding the referral.

SECTION I: Member Information

Member Name (First and Last):____________________ Date of Birth: __________

Member Phone:____________________ Sonder Plan ID: __________

SECTION II: Primary Care Provider (PCP) Information

Primary Care Provider:____________________ NPI: __________

Contact Name:_______________ Phone:__________ Fax: __________

SECTION III: Provider Rendering Services ("Referring To" In-Network Provider Information)

NOTE: if provider is out of network, a Prior Authorization Form must be completed instead of Referral Form

Group Name: ______________________________

Tax ID:_______________ Specialty Type: ____________________

Physician Name:____________________ NPI: __________

Contact Name:_______________ Phone:__________ Fax: __________

SECTION IV: Place of Service (POS Code) & Service Details

Note: Sonder Health Plans may reach out to Specialty Provider to request records for high-level visits.

- ☐ Office/Diag Ctr
- ☐ DME
- ☐ Hm Hlth
- ☐ OP Hospital
- ☐ IP Hospital
- ☐ Am Sgry Cntr
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Other
- ☐ Part B Drugs

POS Code__________

Planed Date(s) of Service, From:__________ To: __________ Appointment Date: __________

Dx Code(s) *(ICD-10)*	**CPT-4/HCPCS** Service Code(s)	**Service Description(s)**	**Visits**	**Units** *per Visits*

PCP Notes/Comments:

SECTION V: Member's PCP Use Only

PCP Signature:____________________ Date: __________