American Specialty Health
American Specialty Health Group, Inc.

eternalHealth™
Your Forever Partner in Healthcare

Referral Form

Incomplete forms will be faxed back.

MEMBER NAME – LAST, FIRST, MIDDLE INITIAL	Is this a member request? Yes No	DATE OF BIRTH	HEALTH PLAN I.D. NO.
MEMBER ADDRESS – STREET, CITY, ZIP CODE			PATIENT PHONE NO.
REQUESTING PROVIDER □ PCP □ SPECIALIST		PHONE NO. ( )	**FAX NO. (MUST HAVE FOR FAX BACK)** ( )
		DATE PREPARED	PREPARED BY / ELIG CHECKED Yes ☐ No ☐

☐ **Routine/Standard:** Routine requests will not exceed five (5) business days from receipt of all necessary information.

REQUESTING PROVIDER NAME	REQUESTINGPROVIDER EMAIL	REFERRAL ISSUE DATE:
ADDRESS – STREET, CITY, ZIP CODE	PHONE NO. ( )	**FAX NO.** ( )
Inpatient Outpatient	FACILITY NAME	INPATIENT GOAL LENGTH OF STAY

DIAGNOSIS	ICD CODE	PROCEDURES/EQUIPMENT	CPT CODE

REASON FOR REFERRAL (PLEASE INCLUDE ALL PERTINENT DOCUMENTATION)

Payment for services is dependent upon the Patient's eligibility at the time services are rendered. Provider to call Health Plan for benefits and eligibility each visit.

IMPORTANT ⇨

*** FAX completed referral forms to (877) 795-2746.**
*** Mail to ASH, 10221 Wateridge Circle, San Diego, CA 92121**
*** Please call ASH at (800)-678-9133 for authorization questions.**

COMMENTS:

REFERRAL EFFECTIVE DATE:

HIPAA Notice: The information contained in this form may contain confidential and legally privileged information. It is only for the use of the individual or entity named above. If the recipient of this form is not the recipient addressed on the form, you are hereby notified that any dissemination, distribution, or copying of the attached document(s) is strictly prohibited. If you have received this in error, please immediately notify the sender by telephone and return the form to the sender. 3 / 3 1 / 1 4