

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.

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|--|---------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Office/Diag Ctr | <input type="checkbox"/> OP Hospital | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Other |
| <input type="checkbox"/> DME | <input type="checkbox"/> IP Hospital | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Part B Drugs |
| <input type="checkbox"/> Hm Hlth | <input type="checkbox"/> Am Sgry Cntr | <input type="checkbox"/> Speech Therapy | POS Code _____ |

Planned 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: _____