



CONSULT VERIFICATION FORM

Complete this form prior to seeking specialist care services.

Mail form to: DocFirst/Primary Select Fax form to:
c/o LBA HealthPlans (410) 427-3699
9475 Deereco Road, #408
Timonium, MD 21093

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.)