Submit Print

Institute for Mental Disease (IMD)Referral Request Form

Conservator's name:_____ **Telephone number:** _____

Initial Enrollment:

☐ **Authorization** ☐ **Retroactive Eligibility** **Start of Service Date:**_____

IMD Referral Request: **Date of Referral:**_____

LTC: *fax 213-438-4877*

☐ **SNF** ☐ **Sub-Acute (Vent)** ☐ **Sub-Acute (Non-Vent)**

UM: *fax 213-438-5777* ☐ **Specialist:**_____ ☐ **Others:**_____

SECTION I

PROVIDER: Authorization does not guarantee payment. L.A. Care Eligibility must be verified at the time the services are rendered.

Patient Name: **Gender :** ☐ **Male** ☐ **Female** **D.O.B:** **Age:**

Mailing Address: **City:** **Zip** **Phone #:**

CIN: **Aid Code:** **County Code:** **County of Conservatorship:**

Primary Insurance: _____
Secondary Insurance: _____ ☐ **Medi-Cal only** ☐ **CMC** ☐ **Medicare FFS**
Medicare Status:
☐ **Benefits NOT Exhausted** **Number of Medicare Days Available:** _____ ☐ **Medicare Advantage Plan:**_____
☐ **Benefits Exhausted** **Date Medicare Benefits Exhausted:** _____

Facility Name: _____
Facility Address: _____
Facility Phone #: _____ **Facility Fax #:** _____
Facility Contact: _____

Physician Name: _____
Physician Address: _____
Physician Phone#: _____ **Physician Fax#:** _____

Diagnosis:

ICD-9 Code/s:

SECTION II
Admitted From:
☐ Home
☐ Board & Care
☐ Acute Hospital
☐ Emergency Room
☐ Another SNF
☐ Other

SECTION III
Reason Referral: _____
_____
_____
_____
_____
_____

SECTION IV
Patient's General Condition:
☐ Elopement Risk ☐ Suicide Risk
☐ Ambulatory ☐ Ambulatory with Assistance
☐ Assaultive Risk ☐ 1:1 needed
☐ Incontinent of B&B ☐ 2:1 needed
☐ Assist with all ADLs
☐ Other _____

SECTION V
Referring Person Name: _____
Relationship or Title_____
Phone Number: _____

Additional Comments: _____
_____
_____