American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
Fax: 877.248.2746

NOTIFICATION OF REFERRAL FOR MEDICAL EVALUATION

For questions, please call ASH at 800.972.4226

Member Name_____
Health Plan Identification Number_____
Health Plan_____ Employer Group_____
Subscriber Name_____
Address_____
City_____ State_____ Zip_____
Phone Number (_____)_____

ASH Contracted Practitioner Name_____
Address_____
City_____ State_____ Zip_____
Phone Number (_____)_____

Primary Care Physician (PCP) or Treating Physician or Primary Medical Group (PMG):

_____

Name of Physician_____

Address (if available)_____

City_____ State_____ Zip_____

The above member has been referred to the PCP or treating physician or PMG on this report for evaluation.

Clinic Chart Number_____

Diagnosis:

_____

_____

Reason for Referral:

_____

_____

_____

Comments:

_____

_____

_____

☐ It WAS necessary to contact the PCP or treating physician or PMG to communicate the reason for the referral and/or make the appointment.

☐ It WAS NOT necessary to contact the PCP or treating physician or PMG to communicate the reason for the referral and/or make the appointment.

Signature of treating Contracted Practitioner_____ Date_____

Distribution: 1) Keep original in member's file.
2) Mail a copy to PMG or PCP or treating physician.
3) Send a copy to the ASH Customer Service department at the address above.

Please call ASH Customer Service at 800.972.4226 if you have any questions.