Helpful Hints: Request an Initial Authorization

Select Location

Select Location Window

Patient Selection

Referral Source Type Patient Last Name Patient First Name Patient DOB Insurance Name Subscriber ID Zip Code City Earliest Authorization Request Start Date Eligibility Information

Patient Information

Patient Information Tab Insurance Name Subscriber ID Patient Last Name Patient First Name Patient Middle Initial Gender Patient DOB Patient Phone Number (Primary) Patient Phone Number (Secondary) Patient Address Patient Zip Code Patient City, State and County

Diagnosis/ Physician/ Services

Search Diagnosis Link Diagnosis Search Window Search by Diagnosis Code Search by Description Selecting Diagnosis Primary Diagnosis Other Diagnoses

Physician Information

Find Ordering and Primary Physician Link Physician Search Window Add New Physician Selected Physician Ordering Physician Primary Care Physician

Services

<u>Find Services</u> <u>Search by HCPC</u> <u>Search by Service Code and UOM</u> <u>Search by Description</u>

Data Entry Instruction for Infusion Services

Drug Units Route Frequency Requested Start Date Requested End Date Time If UOM for this code is Vial, what is the specific physician order? Request Type Types of IV Access Date IV Access Inserted Has the patient had requested drug before? Is the patient or caregiver able and willing to learn to administer the drug(s)? Was the request complete prior to today? Will this medication be administered in an Infusion Suite Setting?

Data Entry Instruction for Infusion Nursing

<u>Units</u> <u>Requested Start Date</u> <u>Requested End Date</u> <u>Time</u> <u>Request Type</u> <u>Was this request completed prior to today?</u>

Delivery Address

<u>Delivery Address Information</u> Is Service to be provided in a Skilled Nursing Facility?

Clinical Information to Support Request

Clinical Information

Data Entry Instructions for Other Services (all other service requests except HIT)

<u>Units</u>

Requested Start Date <u>Requested End Date</u> <u>Time</u> <u>Request Type</u> Was this request completed prior to today?

Requested Services Section

Requested Services

Referral/Facility Information

Referral Source Type Provider Contact First and Last Name, Contact Phone and Contact Fax Facility Search Window Add New Facility Window Facility Admit and Discharge Dates

Attachments/Additional Information

Caregiver Name Caregiver Phone Attachment Type Attaching the File Uploading Files Attachment Size

Final Screen Before submission

Final Screen before submission

Referral Submission

Confirm & Submit Referral Request Button Confirm & Submit Referral Request Final Confirmation Screen

Portal Navigation

<u>Next</u> <u>Previous</u> <u>Save & Exit</u> <u>Cancel</u>

Select Location Window

Select Location Window

Required: Select Location Window will be displayed if you have multiple locations associated with your profile. You are required to pick one location prior to continuing with your referral request. State dropdown shows all states associated with your profile. Once State is selected, City dropdown will be narrowed down based on the State you selected. Select City and click Search to see all provider locations that matched the search criteria entered. Click Select link to choose the location and continue with the referral request.

						[BackToTop
Patient Sear	ch					
					Contact	t Us ? Help
It pays to care at ho	me			Hello CareCentrix Provid	der Portal Demonstration My	Account Sign Out
Home Authorizations	Claims HomeSTAR	E Learning My Tasks Care	entrix Direct User Admin			
Request an Initial Author	vization	You have new CareCentrix Direct re	ferral opportunities for your review. View F	tequests Or Dismiss.		
Please complete the following information in ord	er to get started with your referral su Referral Source Patient Last Name Patient Fins Name Patient DOB	omission. Fields marked with an [*] sign are required [[[[2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	felds. Click <u>HERE</u> for help with these felds. astarts Didering Physician wit initial click and			
	* Insurance Name	5				
	* Patient Home Zip Cod	e 3	3534			
	* Patient Home City	g	IBSONTON			
	* Earliest Authorization	Request Start Date	('MM/DD/YYYY')			
			Cancel Continue			
Provider Lo	cation Details					
Provider Short	Name	Provider Location Name	Address	City State Zip Code	Edit	
PROVIDER DEM	0	KANSAS CITY	6130 Sprint Parkway	CITY KS 66211	Edit	
						[BackToTop]

Referral Source

Required From the dropdown list choose the source of the referral for this request. Referral Source choices include:

- Patient's Discharge Facility
- Patient's Ordering Physician
- Patient's Primary Care Physician
- Patient/Family/Significant Other
- Health Plan
- Sleep Lab

[BackToTop]

Patient Last Name Required: Enter patient's last name.

Patient First Name

Required: Enter patient's first name.

[BackToTop]

[BackToTop]

Patient DOB

Required: Enter patient's date of birth in 'MM/DD/YYYY' format or select date using calendar icon.

[BackToTop]

[BackToTop]

[BackToTop]

[BackToTop]

[BackToTop]

[BackToTop]

[BackToTop]

Close Window

[BackToTop]

Required: Once member details have been entered and user selects "Continue", for certain payers system will indicate the members with which eligibility information was not found. You will be required to select one of the following two options; "Cancel", which will return you to the Patient Search Screen or "Continue", which will allow you to submit your request as entered.

You are responsible for verifying eligibility and benefits with the health plan identified on the patient's identification card. Please ensure the information you have entered in the Patient search is correct. To return to the Patient Search Screen please click Cancel. If you would like to proceed with submitting this request as entered, click Continue Cancel

more than one city matches the zip code entered, pop-up message will be displayed allowing user to select city. [BackToTop]

Required: City field will be auto populated once valid zip code is entered. If more than one city matches the

zip code entered, pop-up message will be displayed allowing user to select city.

Required: Select date from calendar or enter the earliest authorization request date manually.

Required only for certain health plans: County field will be auto populated once valid zip code is entered. [BackToTop]

Required only for certain health plans: Enter Zip Code

Required: Select Insurance Name from dropdown list.

Subscriber ID

Insurance Name

Required: Enter patient's subscriber ID.

Zip Code Required: Enter Zip Code

City

Service/Delivery Location Zip Code

Earliest Authorization Request Start Date

Service/Delivery City Required only for certain health plans: City field will be auto populated once valid zip code is entered. If

Service/Delivery County

Eligibility Information

Eligibility Information

Patient Information

Patient Information	
* Insurance Name	CIGNA PPO
* Subscriber ID	U12345678
* Patient's first name	TEST
* Patient's last name	TEST
* Gender	MALE 🗸
* Date of birth ('MM/DD/YYYY')	01/01/1971
* Patient's primary phone	(999) 999 9999
Patient's phone (secondary)	
* Patient's address	9119 CORPORATE LAKE DR.
* Patient's zip code	33614
Patient's city	ТАМРА
Patient's state	FLORIDA
Patient's county	HILLSBOROUGH

Patient Information

Patient Information will display additional patient information fields that are required or optional for your referral request. All required fields are marked with an asterisk sign. Note, that some of the patient's information entered during the patient search will be pre-populated on the screen and may not be editable. [BackToTop]

Insurance Name

Subscriber ID

Required and Non-Editable Unless Adding a New Patient: Pre-populated from the existing patient record or from information entered on the search screen. [BackToTop]

Required and Non-Editable Unless Adding a New Patient: Pre-populated from the Patient Information selection. Based on the insurance selection, additional question may display that require responses.

Patient Last Name Required and Non-Editable Unless Adding a New Patient: Pre-populated from the existing patient record or from information entered on the search screen.

Patient First Name Required and Non-Editable Unless Adding a New Patient: Pre-populated from the existing patient record or from information entered on the search screen.

Required and Editable: Pre-populated from the existing patient record. If new patient record is added you will be required to choose from dropdown list.

Required and Non-Editable Unless adding a New Patient: Pre-populated from the existing patient record or from information entered on the search screen.

Patient Phone Number (Primary) Required: Pre-populated from the existing patient record. Enter 10 digit phone number where the patient will receive services or where the patient/caregiver/reliable neighbor can be contacted.

Gender

Patient DOB

[BackToTop]

[BackToTop]

[BackToTop]

[BackToTop]

[BackToTop]

[BackToTop]

Patient Phone Number (Secondary) Optional: Enter 10 digit phone number if provided.

Patient Address

Required and Editable: Pre-populated from the existing patient record. If new patient record is added you will be required to enter patient address to continue. [BackToTop]

Required and Editable: Enter Zip Code. Pre-populated from the existing patient record or from information entered on the search screen. The zip code value can be changed at any time during referral submission. If more than one city matches the zip code entered, pop-up message will be displayed allowing user to select a city.

Patient City, State and County

Required: Patient city, state and county fields will be auto populated once valid zip code is entered. When the zip code is changed the system will automatically update the city, state and county.

Insurance Information

Some health plans will require additional insurance information to be entered.

[BackToTop]

Diagnosis Information

Diagnosis/Physician									
Please enter the Diagnosis, Ordering Physician and Primary Care Physician. Fields marked with * are required fields. Click <u>HERE</u> for help with these fields.									
* Diagnosis	Search								
	ICD Code	Version	Description						
*PRIMARY				Edit					
OTHER				Edit					
OTHER				Edit					
OTHER				Edit					

Search Diagnosis Link

Click on the Search link to navigate to the Diagnosis Search window where you can add diagnosis information for this referral. Click on Edit link to edit or delete a diagnosis you already added for this referral.

[BackToTop]

Diagnosis Search Window

The Diagnosis Search window allows searching by diagnosis code or diagnosis description. You are required to select the desired search criteria radio button (diagnosis code or description) to continue with the search.

Patient Zip Code

[BackToTop]

	gnosis selected in this search by clicking on the	e edit link displayed in the Services section.
Search by O Diagnosis Code OR O Descrip	tion	
elected Diagnosis		
Code I	Description	Delete
PRIMARY		Delete
THER		Delete
THER		Delete
THER		Delete
	Cancel Save	

Search by Diagnosis Code

Enter ICD-10 code with or without decimal. You are required to enter more than one digit to see the search results. Click Search to see the results that match the criteria you entered.

Search by Description

Enter description of diagnosis you are looking for. You are required to enter more than three characters to see the search results. Click Search to see the results that match the criteria you entered.

[BackToTop]

Selecting Diagnosis

If one or more matches are found for the search criteria, corresponding code and descriptions and Select links will be displayed. Click Select link to add the diagnosis to the record. Each diagnosis selected displays in the Selected Diagnosis section below in the order selected. The first diagnosis selected will display as the primary diagnosis. You are allowed to enter up to four diagnoses (primary, secondary, tertiary and other).

Primary Diagnosis

Required: Primary diagnosis field is required for the referral submission. You can click Delete Link in the Selected Diagnosis section to remove the selection.

[BackToTop]

Other Diagnoses

Optional: Other diagnoses are optional for the referral submission. Selecting all diagnoses relevant to services you are requesting will facilitate the review and processing of your request. You can click Delete link in the Selected Diagnosis section to remove the selection.

[BackToTop]

Physician Information

[BackToTop]

1	Physician Search										
	First Name	Last Name	NPI	City	Zip						
	*ORDERING					Edit					
	PRIMARY					Edit					

This section allows for the entering of the Ordering Physician and Primary Care Physician. All required fields are marked with an asterisk sign.

[BackToTop]

Physician Link

Click on the Search link to navigate to the Physician Search window, where you can add new physician information for this referral. Click on Edit link to edit or delete a physician you already added for this referral.

[BackToTop]

Physician Search Window

The Physician Search information can be added by performing a search or by manually adding the physician to the referral. You can search for physician records by entering a combination of the following criteria: physician first and/or last name, address including city, state and zip code, NPI, phone number.

If multiple records are found matching the physician information, results display that match the search criteria. Locate the physician in the listing that is an exact match for the search criteria. You can click Ordering link, Primary Care link or Both link to add selected as ordering physician, primary care physician or both.

Physician Search										c	lose Window
Search for Ordering and Primary Phy Ordering or Primary Physician by cli-	ysician. Enter search criteria cking on the edit link display	in at least 2 fields. Your se ed in the Services section.	elections will b	e applied to eac	sh service y	ou add to the Service	s section below. Aft	er you have	added a serv	rice you ma	ly edit the
Please ensure that you select/insert i information can result in a HIPAA vi- name, address and NPI number can	the correct name, address an olation because it can cause change. If you are unsure of	d NPI number for the orde a communication contain the physician name, add	ring physician ing protected ess and/or NPI	and PCP. As a health informati number, please	Covered En on to be mi e contact th	ntity, you are obligate isdirected to an incom e physician directly to	d to comply with HI ect physician and/o verify this informat	PAA. Failure r address. Pl ion.	to select/ins ease remem	ert the corr ber that the	ect • physician
Physician Last Name		Physician First Name				NPI					
City		State		FL 🗸		Zip Code					
Phone]									
		Clear	Ad	d llew Physic	ian	Search					
Selected Physician											
Selected Physician			_	_			_	_	_		_
First Nan	ne Last Name	Address	City St	tate Zip Code	Phone	NPI	Tax Id	Network Status	Provider type	Source	Delete
*ORDERING											Delete
PRIMARY CARE											Delete
			Can	icel Save							

[BackToTop]

Add New Physician

If physician search could not locate the correct physician record, you can click Add New Physician to add the physician to the record. All fields required for adding new physician record are marked with an asterisk sign. Add New Physician window also has radio buttons that allows you to add new physician entry as ordering physician, primary physician or both.

Note that the system will not allow you to add a new physician using the Add New Physician button until you perform an initial search for the physician.

Add New Physician Please ensure that you select/ins Failure to select/insert the correct incorrect physician and/or addree number, please contact the physician	eert the correct name, address and NPI nu t information can result in a HIPAA viola ss. Please remember that the physician r sician directly to verify this information.	umber for the o tion because i ame, address	rdering physician and PCF t can cause a communicati and NPI number can chang	P. As a Covered Entity ion containing protect ge. If you are unsure of	Close Windov , you are obligated to comply with HIPAA. ed health information to be misdirected to an f the physician name, address and/or NPI
* First Name		* Zip Code		NPI	
* Last Name		City		* Pho	1e
* Address		State		Fax	
Provider Type	Select 🗸	Tax Id			
	Add As Ordering Phys Cancel	ician () Add	As Primary Care Physician	n O Add as Both	[BackToTop]
Ordering Physicia Required: Ordering	ın J Physician field is requir	red for th	e referral subm	ission.	[BackToTop]
Primary Care Phy Optional: Primary (<mark>sician</mark> Care Physician field is no	ot require	ed for the referra	al submissior	n. [<u>BackToTop</u>]

Requested Services

This section allows identifying all services being requested with this referral submission. All required fields are marked with an asterisk sign. Additionally, user is able to edit the diagnoses and the physician information at the service code level.

	HCPC + Modifiers	CCX Code	UOM	Units	Start Date		End Date	Description	
FI	E0154 - NU	2033	PUR	1	11/05/2015		11/05/2015	WALKER PLATFORM ATTACHMENT, EA	[¥]
Physician	Edit								
		First Name	Last Name		City	NPI		Zip Code	
*ORDERING		MARIA	ARTZE		WEST PALM BEACH	1588629810		33401	
PRIMARY									
Diagnosis	Edit								
		ICD Code		Version	Description				
*PRIMARY		E011		10	IODINE-DEFICIENCY RELA	TED MULTINODULAR (ENDEMIC) GOITER		
OTHER									
OTHER									
OTHER									

Find Services

Required: Allows searching by HCPC, Service Code + UOM, or Description. Corresponding radio buttons are included that allow specifying the criteria for the search.

services that match the search criteria and click Select link to pick the desired service.

Search by HCPC

Search by Service Code + UOM

To search by Service Code and UOM, select the Service Code & UOM search option, enter the service code in the Service Code field. Select the unit of measure from the UOM dropdown list, and click the Search button. If multiple records are found matching the search criteria, results display in the section below. Locate the services that match the search criteria and click Select link to pick the desired service. [BackToTop]

To search by HCPC, select the HCPC search option, enter the HCPC code, and click the Search button. If multiple records are found matching the search criteria, results display in the section below. Locate the

Search by Description

Request Services

To search by Description, select the Description search option, enter a detailed description or brand name in the Description field, and click the Search button. If multiple records are found matching the search criteria, results display in the section below. Locate the services that match the search criteria and click Select link to pick the desired service.

[BackToTop]

Close Window

[BackToTop]

Data Entry Instructions for Infusion Services

CPC: J3370	CCX Code: 7372	CCX UOM: EA	MODIFIERS:	CAT ID: MED	Units:	Time frame:	
* Drug			VANC	OMYCIN HCL, UP TO 500 MG	;		
* Units (for drug	gs, please state units per dose	e)					
* Route			Select		~		
* Frequency			Select				
* Requested St	tart Date						
Requested S	tart time			(HH:MM AM/PM)			
* Requested Er	nd Date						
Requested Er	nd time			(HH:MM AM/PM)			
* Request Type	9		Select	\checkmark			
Types of IV Ac	cess		Select				
Other Value							
Date IV Acces	s Inserted						
Has the patien	t had the requested drug befo	pre?	Oyes	ONo			
Is the patient of	or a Caregiver able and willing	to learn to administer the drug	g(s)? Select			\sim	
Will Infusion P	rovider be providing the Nursi	ing related to the Infusion Ther	rapy? Oves	ONO			
* Was the servi to submitting thi	ice or item for which you are r is request for authorization?	now requesting authorization ir	nitiated prior Oves	ONo			
Mill this modie	ation ho administered in an Ir	fusion Quito Cotting?	<u> </u>	<u>∩</u>			>

Cancel Add to Requested Services

Drug

Required and Non-Editable: Will pre-populate based on the services selected in the Find Services sections. Note: The filed has been lengthened to allow most, if not all, of the drug name and strength/concentration to display.

[BackToTop]

Units

Required: Specify the number of units that are going to be given to the patient at each infusion/injection/administration, based on the unit of measure and strength/concentration. Example: the UOM is a vial and each vial contains 20 grams. Each administration consists of 120 grams, or SIX VIALS; therefore, enter six units.

[BackToTop]

Route

Required: Click on the dropdown and select from the following:

- o Continuous IV
- o Intermittent IV
- o IM PD
- o Subcutaneous Continuous
- o Subcutaneous Injection
- o Aerosolized

[BackToTop]

Frequency

Required: Select the "Frequency" from the drop down selection box and enter the appropriate numeric value in the blank space below it.

The Frequency drop down selection box will contain the following:

- o Per Day
- o Per Week
- o Per Month
- o Every X Hour(s)
- o Every X Week(s)

Once a Selection is made in the "Frequency" drop down box, another field will appear below it. A numeric value should be entered in this field

- o ____ Times Per Day
- o ____ Times Per Week
- o ____ Times Per Month
- o Every ____ Hour(s)
- o Every ____ Week(s)

Detail:

If the user selects '**Per Day**' from the drop down box, then '<u>times **Per Day**</u>' will activate. Enter the numeric value for the number of times per day the medication is administered.

If the user selects 'Per Week' from the drop down box, then '____ times Per Week' will activate. Additionally user will be required to enter "Day(s) of week medication to be infused". If user enters more than 6 times per Week, the following 'Frequency Validation' message will be displayed, "You may only enter up to 6 times per week. If you would like to enter 7 or more, please select per day frequency."

If the user selects 'Per Month' from the drop down box, then '____ times Per Month' will activate.

Additionally user will be required to enter "Day(s) of month medication to be infused". If user enters more than 3 times per Month, the following 'Frequency Validation' message will be displayed, "You may only enter up to 3 times per month. If you would like to enter 4 or more, please select per week frequency."

If the user selects **'Every X Hour(s)'** from the drop down box, then **'Every ____ Hour(s)'** will activate. Enter the numeric value for the number of hours between each administration.

If the user selects 'Every X Weeks' from the drop down box, then 'Every ____ Weeks' will activate. Enter the numeric value for the number of weeks between each administration. [BackToTop]

Requested Start Date

Required: Enter the start date for the drug or select date using calendar icon.

Requested End Date

Time

Required: Enter the end date for the drug or select date using calendar icon.

Optional: Specify the time for the start of care for the infusion therapy. Time should be entered in "HH:MM AM/PM" format.

If the UOM for this code is Vial, what is the specified physician order?

Required when vial UOM is selected: Enter the full order including the drug/medication name, dose (in grams, milligrams, liters, milliliters etc), route, frequency and duration. For example: Ampicillin 1 gram IV Q8 x 14 days. [BackToTop]

Required: Select the request type of Routine, Urgent, or Expedited from the Request Type dropdown list. Expedited is only used when the ordering physician has ordered the service to be delivered/provided as expedited.

Optional: Indicate the type of infusion catheter or "line" the patient has. Click on the drop down arrow and select from the following:

- o Groshong
- o Hickman
- o Implantable Port
- o Midline
- o Peripheral IV
- o PICC
- o Other

Date IV Access Inserted

Optional: Enter the date the line was inserted or select the date using the calendar icon.

[BackToTop]

Has the patient had the requested drug before?

Optional: Select the "Yes" or "No" radio button to identify if the patient has had the requested drug(s)

Types of IV Access

Request Type

[BackToTop]

[BackToTop]

[BackToTop]

[BackToTop]

Required: Select the "Yes" or "No" radio button to identify if this request was completed p	prior to today. [BackToTop]
Will this medication be administered in an Infusion Suite Setting? <i>Optional:</i> Select the "Yes" or "No" radio button to identify if this medication will be administered in the setting.	stered in an
initiation duite detung.	[BackToTop]
Data Entry Instruction for Infusion Nursing	
Units <i>Required:</i> Enter number of Units being requested.	[BackToTop]
Requested Start Date Required: Enter the authorized start date for care.	[BackToTop]
Requested End Date Required: Enter the authorized end date for care.	[BackToTop]
Time <i>Optional:</i> Specify the time for start of care. Time should be entered in "HH:MM AM/PM" f	ormat. [<u>BackToTop</u>]
Request Type Required: Select the request type of Routine, Urgent, or Expedited from the Request Tyre	e drondown li

Required: Select the request type of Routine, Urgent, or Expedited from the Request Type dropdown list. Expedited is only used when the ordering physician has order the service to be delivered/provided as expedited.

Was this request completed prior to today? Required: Select the "Yes" or "No" radio button to identify if this request was completed prior to today. [BackToTop]

Delivery Address

Optional: Specify from the dropdown list the appropriate response of "Yes", "No", or "Drug(s) not

appropriate for Patient or Caregiver to administer".

Is the patient or a Caregiver able and willing to learn to administer the drug(s)?

Was this request completed prior to today?

before.

[BackToTop]

[BackToTop]

Request Services

HCPC: K0007	CCX Code: 8878	CCX UOM: PUR	MODIFIERS: NU	CAT ID: HME	Units:	Time frame:
Delivery Address						
The address given b	elow represents the patient's hon	ne address as entered in the P	atient Information screer	n. If the delivery address for t	his service dif	iers from the given
address please upda	te accordingly.					
Location Name			PATIE	NT HOME		
Contact Name			TEST	TEST		
Address			TFOT			
71001000			TEST			
Phone			(999) 9	99-9999		
Zip Code			33549			
State						
otato			FL			
City			LUTZ			
¹ Is Service to be	provided in a Skilled Nursing Fa	acility?	⊖ Ye	s 🖲 No		

Delivery Address Information

Optional: Review the Delivery Address information. The information displayed in the Delivery Address fields pre-populate based on the patient address information as entered in the Patient Information screen. If the delivery address is different than what is displayed, type over the current information to update each field.

[BackToTop]

Is Service to be provided in a Skilled Nursing Facility?

Required: Select "Yes" or "No" radio buttons to specify if the services will be provided in a Skilled Nursing Facility (SNF).

[BackToTop]

Clinical Information to Support Request

Clinical Information

Required: If the requested service requires clinical information, corresponding clinical template questions will be displayed. All of the clinical questions are required for processing the request. Please take time to provide responses to clinical questions. Answers to clinical questions will help us make authorization decision faster and will reduce follow-up calls required in order for us to make the decision.

[BackToTop]

Data Entry Instructions for Other Services (all other service requests except HIT)

Units

Required: Enter the number of units or amount of services you would like authorized (number of visit, hours, etc.) This needs to be calculated to include all units necessary for the authorization time period. [BackToTop]

Requested Start Date

Required: Enter the authorized start date for care or equipment delivery.

Requested End Date

Required: Enter the authorized end date for care or equipment delivery.

[BackToTop]

Additional Information

Attachment Type

Please Specify attachment type selecting one of the values from the dropdown list:

Note that you will be required to select attachment type for each file you are uploading.

Attachment	SELECT Browse Upload	
	Cancel The Entire Request Save & Exit Confirm Request	

Attaching the File

Optional: Upload supporting documentation for the services requested if required. Word, PDF and Image files may be uploaded Description.

[BackToTop]

[BackToTop]

Uploaded Files

All uploaded files will be displayed at the bottom of the Services screen. You can click Delete to remove uploaded documents.

[BackToTop]

Attachment Size

Attachment file size limit is 5MB. You will receive an error message and will not be able to upload the file if its size exceeds allowed limit.

[BackToTop]

Confirm Request After you have ente

After you have entered all the information, press Confirm Request. The system will alert you if any additional information is needed or there are other issues with your request. Please take the time to fix these issues so that your request can be processed quicker. If additional information is needed, below are the types of information we will ask for.

[BackToTop]

Referral Source The referral source will populate from the search screen. If the referral source was a facility, we will ask for the facility information.

[BackToTop]

Provider Contact First Name

Optional First name of the provider contact

[BackToTop]

Provider Contact Last Name

Optional Last name of the provider contact.

Provider Contact Phone number

Optional The phone number for the provider contact.

Provider Contact Fax

Optional Enter the fax number for the provider contact.

Referral Source					
Please enter the referral source and facility information. Fields marked with an [*] are required fields. Click <u>HERE</u> for help with these fields.					
* Referral Source	Patient's Discharging Facility	* Add Facility			
* Provider Contact First Name:		* Provider Contact Last Name:			
* Provider Contact Phone Number:		Provider Contact Fax:			
* Provider Contact Method	O Phone O Email O ECIN				

Facility

Facility Search Window

You can perform facility search by entering Facility Legal Name, Facility DBA Name, City, State, Zip Code, or any combination of these fields. Adding City, State and/or Zip Code will help narrow down search results.

If multiple records are found matching the facility information, results will display that match the search criteria in the section below. Locate the facility that matches the search criteria and click Select to add the correct facility.

Clicking Select link will populate facility information that you selected to Diagnosis/Facility Tab. You can click Delete link to remove the facility selection and perform a new facility search.

If facility search could not locate the correct facility record, you can click Add New Facility to add the facility information.

Facility Search		Close Window			
Enter at least two of the following search criteria to find the facility you are looking for.					
Facility Legal Name					
Facility DBA Name					
City	State FL V Zip Code				
	Clear Add New Facility Search				

[BackToTop]

[BackToTop]

[BackToTop]

[BackToTop]

Add New Facility Window

Required: If facility search could not locate the correct facility record, you can click Add New Facility to add the facility information. All fields shown on Add New Facility window are required. Note that you will not be allowed to add a new facility using the Add New Facility button until you perform an initial search for the facility.

Facility Admit and Discharge Dates

Required: Enter facility admission and discharge dates or select dates using calendar icon.

The facility information will auto-populate to the facility section

Known Allergies

Optional: Enter the patient's known allergies if you have it.

Height (in inches)

Optional: Enter the patient's height if you have it.

Weight (in pounds) Optional: Enter the patient's weight if you have it.

Caregiver Name

Optional: Enter the name of the person who will care for the patient. Enter "self" if the patient will care for him/herself.

Caregiver Phone

Optional: Enter the 10 digit phone number for the patient's caregiver.

Final Screen Referral Submission

Confirm Request Button –

Required: Clicking the Confirm Request button will bring you to the final step in processing the service request, where you can validate accuracy of information entered.

[BackToTop]

Submit Referral Request

Required: The final step in processing the service request is to validate the accuracy of the information entered for the request. Once the user clicks the Submit Request button, a summary of the referral details display. Review the information in each section carefully to ensure all information entered is accurate and all services requested have been added. If any warnings remain, user can acknowledge the warning and check the box to proceed with submitting the request.

Click the Submit Request button to complete the referral request. Click the Previous button to return to the Services screen. Click the Save & Exit button to store the information without completing the referral process. Information that is saved will be stored in the Portal for 7 days.

[BackToTop]

[BackToTop]

[BackToTop]

[BackToTop]

[BackToTop]]

[BackToTop]

Clicking the Previous button will navigate user to the previous screen. Data entered on the current screen will be saved so that user can come back and continue with request.

[BackToTop]

Save and Exit

Clicking the Save & Exit button will allow user to save data entered and navigate them to Portal home page. The referral request will be saved and available to the logged in user for 7 days after initiation of the referral request.

[BackToTop]

Cancel The Entire Request

Clicking the Cancel The Entire Request button will allow user to cancel the entire request and create a No Admit Record.

[BackToTop]

Thank you Screen

The final confirmation screen displays if your referral was submitted successfully to CareCentrix. [BackToTop]

Portal Navigation

Next Clicking the Next button will navigate user to the next screen after validating that all required information is

entered.

Previous