EXHIBIT C

SPECIALTY CARE REFERRAL FORM

Please submit this form to: **Advantek Benefit Administrators**
P.O. Box 1507, Fresno, CA 93716-1507
Attn: Jeanisha Dennie/FAX# (559) 228-4279

1. Date of Request:____/____/_____	**2.** Date Client Last Seen by Requesting Physician:____/____/____

PATIENT INFORMATION

3.	Patient Name: Last First Middle	Date of Birth (Mo/Day/Yr):	Age:	Gender: M F
4.	Address: Street City State Zip Code	Phone Number: ( )		

5. Does patient have Restricted Medi-Cal? Yes No MEDS Aid Code: ____________________

- If "Yes", what is the patient's BIC/CIN Number? __________________________
- If "No", is the patient's Medi-Cal application pending? Yes No Medi-Cal application date:_____________

REQUESTING CLINIC/HOSPITAL INFORMATION

6.	Requesting Physician (please print):	Tax ID #:	Clinic Name:	
7.	Contact Person in Requesting Provider's Office:	Telephone #: ( )	Fax #: ( )	Name of PCP (if different than requesting physician):
8.	Requesting Clinic/Hospital Address: Street City State Zip Code			

REFERRAL REQUESTED

9.

☐ Cardiology	☐ Dermatology	☐ Endocrinology	☐ Gastroenterology
☐ Inpatient Hospitalization	☐ Laboratory Services	☐ Neurology	☐ Gynecology
☐ Oncology	☐ Ophthalmology	☐ Oral/Maxillofacial	☐ Orthopedics
☐ Otolaryngology (ENT)	☐ Outpatient Surgery	☐ Pharmacy Services	☐ Pulmonology
☐ Urology	☐ Radiology, including Computerized Tomography (CT) Scans and Magnetic Resonance Imaging (MRI)		

CPT Codes:____ Other:____

CLINICAL INFORMATION

10. Medical Diagnosis	ICD-10 Code	Date of Onset month/year

11. Referring Physician Comments:

____

____

____

Client clinical data attached: Lab Reports: ☐ X-ray: ☐ Narrative Reports: ☐ Medication Report: ☐

☐ Other: ____

APPLICANT'S LANGUAGE PREFERENCE

12. I prefer to speak in the language checked below:
Prefiero hablar el idioma indicado a continuación:

English/Ingles ☐

Spanish/Español ☐

Other/Otro ☐ What language do you speak/Qué idioma habla:__________________

Please tell us which language or format you would prefer for your written information:
Por favor, indique cual idioma o formato usted prefiere para su información escrita:

English/Ingles ☐

Spanish/Español ☐

Other/Otro ☐ What language do you read and write/En qué idioma usted lee y escribe:____________________

APPLICANT'S ATTESTATION
(Sign one of the attestations below dependent upon language preference)

13. I, __________________________________, attest the following is true and correct under penalty and perjury
under the laws of the State of California: (1) I am currently a resident of the County of Fresno; (2) I do not have a household income that exceeds 138% of the current Federal Poverty Level; (3) I have applied for full scope Medi-Cal benefits; and (4) I have exhausted all other health care options available to me, including but not limited to third party payors such as private insurance, the U.S. Department of Veterans Affairs, Worker's Compensation, Medicare, through my own or my spouse's place of employment, through my parent(s) or guardian(s), or motor vehicle or homeowner insurance coverage.

I acknowledge and understand that submission of this referral form is only to obtain necessary non-emergency specialty care services listed herein and is solely dependent upon available funding to reimburse qualified specialty care medical providers who may perform such services.

I understand and acknowledge that I do not have a legal right to receive non-emergency specialty care services and that such services are dependent upon my continued eligibility and the availability of such funding.

(Applicant's Attestation continues on Page 3)

Further, I do waive, release and forever discharge any and all claims or actions, known or unknown, that I may have against the County of Fresno and Santé Health System, d.b.a. Advantek Benefit Administrators, pertaining to the processing of this referral form and receipt of non-emergency specialty medical services.

Applicant Signature: ____ Date: _________________

OR

Yo, ________________________________, doy fe de que lo siguiente es verdadero y correcto bajo pena de perjurio en virtud de las leyes del estado de California: (1) actualmente resido en el condado de Fresno; (2) no poseo ingresos familiares que superen el 138 % del nivel de pobreza federal; (3) he solicitado beneficios de Medi-Cal integrales; y (4) he agotado todas las demás opciones de atención médica que tenía disponibles, lo que incluye a mero título enunciativo pagos por parte de terceros, tales como seguro privado, el Departamento de Asuntos de los Veteranos de los EE. UU., indemnización por accidente laboral, Medicare, a través de mi propio lugar de trabajo o el de mi cónyuge, a través de mis padres o tutores, o cobertura de seguro del propietario de vivienda o vehículo motorizado.

Reconozco y entiendo que la presentación de este formulario de remisión tiene como único fin obtener los servicios de atención especializada necesarios y que no sean de emergencia enumerados en el presente y que esto depende únicamente de la disponibilidad de fondos para reembolsar a los proveedores médicos de atención especializada que pudieran prestar dichos servicios.

Reconozco y comprendo que no tengo derecho legal a recibir servicios de atención especializada y que no sean de emergencia, y que dichos servicios dependen de mi elegibilidad continua y de la disponibilidad de dichos fondos.

Asimismo, renuncio, libero y exonero para siempre cualesquiera reclamos o acciones, conocidos o desconocidos, que pudiera tener en contra del condado de Fresno y Santé Health System, que opera bajo el nombre de Advantek Benefit Administrators, en lo referido al procesamiento de este formulario de remisión y a la recepción de servicios médicos especializados que no sean de emergencia.

Firma del solicitante: ____ Fecha: ____________

PHYSICIAN'S ATTESTATION
(Sign one of the attestations below dependent upon patient care setting)

REQUESTING PRIMARY CARE PHYSICIAN'S ATTESTATION

14.

I, ________________________________, attest it is true and correct under penalty and perjury under the laws of the State of California that I provided primary care services to the Applicant and that Applicant has a need for non-emergency specialty medical services necessary to avoid endangerment to life or health.

Physician Signature: ____ Date: ________________

OR

REQUESTING EMERGENCY DEPARTMENT PHYSICIAN'S ATTESTATION

I, ________________________________, attest it is true and correct under penalty and perjury under the laws of the State of California that I provided emergency department services to the Applicant and that Applicant has a need for non-emergency specialty medical services necessary to avoid endangerment to life or health.

Physician Signature: ____ Date: ________________

EXHIBIT C

INSTRUCTIONS FOR COMPLETING THE SPECIALTY CARE REFERRAL FORM

1. Date of Request: Enter the date the form is completed.

2. Date Client Last Seen by Requesting Physician: Enter the date the patient was last seen by the referring physician.

Patient Information

3. Patient Name: Enter the patient's last, first, and middle names, date of birth, age at the time of request and gender.

4. Address and Phone Number: Enter the patient's street address, city, state, and zip code. Do not enter a P.O. Box number unless that is the patient's street address. If the patient does not have an address because he/she is homeless, enter "none" or "homeless" in this area. If left blank, the form is considered incomplete and will be denied. Enter the patient's home or cell phone number, including the area code.

5. Does Patient have Restricted Medi-Cal: Circle "Yes" if the patient has Restricted Medi-Cal and enter the MEDS Aid Code and patient's Medi-Cal BIC/CIN number. Circle "No" if the patient does not have Restricted Medi-Cal. If "No" is circled, answer whether or not the patient's Medi-Cal application is pending by circling either "Yes" or "No" and enter the date the patient applied for Medi-Cal and leave the MEDS Aid Code blank.

Requesting Clinic/Hospital Information

6. Requesting Physician, Tax ID # and Clinic Name: Enter the full name of the requesting physician, which may be either the emergency care or primary care physician. Enter the Tax Identification number of the federally funded clinic or emergency hospital. Enter the name of the clinic or hospital.

7. Contact Person in Requesting Provider's Office, Telephone #, Fax #, and Name of PCP: Enter the name of the contact person in the clinic or hospital that can be contacted regarding the referral, his/her telephone and FAX number, and the name of the patient's primary care physician if the requesting physician is not the patient's primary care physician.

8. Requesting Clinic/Hospital Address: Enter the complete street address of the requesting clinic or hospital. Do not enter the clinic or hospital's corporate address unless this is also the address where the requesting physician provided medical care to the patient.

Referral Requested

9. Referral Requested: Check the box next to the type of referral requested and enter the CPT Code of the requested specialty service where indicated.

Clinical Information

10. Medical Diagnosis, ICD-10 Code, and Date of Onset: The Medical Diagnosis, ICD-10 and Date of Onset must be filled in by the referring physician.

11. Referring Physician Comments and Client Clinical Data Attached: Referring physician comments and attaching any clinical data is optional for submittal of the Form to Advantek; however, if request is approved, the specialist may require specific patient clinical data at his/her discretion.

Applicant's Language Preference

12. Spoken Language and Written Language: Patient must mark his/her language that he/she speaks and reads and writes by checking the appropriate box. If "Other" is marked, enter the other language where indicated. If client does not speak (including sign language), read or write, enter "None" where appropriate.

Applicant's Attestation

13. Applicant's Attestation: The patient must fill in his/her full name, sign, and date the Applicant's Attestation in his/her appropriate language. If the applicant indicates he/she speaks, reads, and/or writes in a different language, the County may provide the applicant with an attestation translated to his/her language for signature as soon as possible.

Physician's Attestation

14. Requesting Primary Care Physician's Attestation **or** Requesting Emergency Department Physician's Attestation: Fill in the requesting physician's name and sign and date the appropriate attestation for either primary care or emergency department.