WELLHEALTH Quality Care
A MedSource Health Care Company

TEACHERS HEALTH TRUST
For Teachers By Teachers

Referral Request Form: Pre-Existing Relationships ONLY

Member Information

Name _____

Member ID # _____

Cell Phone Number _____

Email Address _____

Provider Information

Specialist Name _____

Specialty Type _____

Specialist Group (if known) _____

Primary Care Physician _____

History

Last Date of Service with Specialist _____
(Last date of service must be between January 1, 2015 and March 31, 2016 to qualify)

Date of Next Appointment Scheduled with Specialist _____

☐ **I am attaching official documentation of my relationship with this provider.**

Important Notes

- Please include any documentation of previous relationship with the above name specialist for verification.
- If documentation cannot be provided, please be aware that approval process will take longer.
- If the Teachers Health Trust cannot verify a previous relationship with the above named specialist, your request will be denied.

Please email this form to advocates@wellhealthqc.com

Or fax to (702) 357-3447

Internal Use Only

Date Received _____ Verified By (Manager) _____ Date _____

Documentation Submitted _____ Referral Created by _____ Date _____