

## HERE TO THERE PROGRAM NOTIFICATION FORM

MEMBER INFORMATION	REFERRING PHYSICIAN
Today's Date: ____/____/____ Name: _____ Date of Birth: ____/____/____ ID# ____-____-____-____-____-____-____-____	Name: _____ Provider #: _____ Contact: _____ Phone #: _____ <b>DIAGNOSIS(ES)</b> _____ _____
TREATING PHYSICIAN	TYPE OF SERVICE
Physician Name: _____ Speciality: _____ Address: _____ _____ Telephone: _____ Fax: _____	Please note: Any advanced imaging services (MRI, CT, PET) must be requested through eviCore healthcare at (888) 693-3211 or myportal.medsolutions.com. <input type="checkbox"/> <b>Office Visits</b> Date of Visit: ____/____/____ # of Visits _____ <input type="checkbox"/> <b>Hospitalization</b> Inpatient Admission: ____ Surgical Day: ____ Observation: ____ Procedure/CPT Code(s): _____ Admit Date: ____/____/____ # of Pre-Op: ____ # of Post-Op: ____
AFFILIATED HOSPITAL	
<input type="checkbox"/> Beth Israel Deaconess Medical Center <input type="checkbox"/> Dana Farber Cancer Institute <input type="checkbox"/> Massachusetts General Hospital <input type="checkbox"/> Boston Medical Center <input type="checkbox"/> Lahey Clinic <input type="checkbox"/> New England Baptist Hospital <input type="checkbox"/> Brigham and Women's Hospital <input type="checkbox"/> Massachusetts Eye and Ear Infirmary <input type="checkbox"/> Tufts New England Medical Center, Inc. <input type="checkbox"/> Children's Hospital Medical Center	
Total Visits Allowed: ____ Start Date: ____/____/____ End Date: ____/____/____ Notification#: _____ Notification is for: _____	
COMMENTS	
_____ _____ _____ _____	