

Restricted Recipient Program

Create a new Authorization or edit Member information (see [Getting Started](#)).

Note: All fields with a red asterisk are required.

Select Restricted Recipient Program (RRP) Referral Form from the *Authorization Type* dropdown menu and fill out *Submitter Information* in full.

PrimeWest HEALTH

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Create Authorization

Member				
PMI #	Last Name	First Name	Date of Birth	Soc Sec #
99999001	Primewest	Mary	07/01/1954	

New Search

Authorization Type*

Restricted Recipient Program (RRP) Referral Form

Submitter Information

First Name* Last Name* Phone* Ext:

Stephanie Hoberg (320) 762-5949

Email*

stephanie.hoberg@primewest.org

Start Date* **End Date***

12/13/2018 06/26/2019

Fill out required fields for all services and procedures allowed.

Required fields when creating a Service Authorization

Are you the member's "Restricted To" provider at time of service?*			
Yes ▼			
Reason for visit*			
Consult and treat			
Authorization Type (Level)*			
Prof Med Svc-Specialty Care [OOP Specialty ▼]			
Primary Diagnosis			
Primary ICD 10 Code*		Diagnosis Description	
K80.00		Calculus of gallbladder w acute cholecyst w/o obstruction	
Procedure Code			
Procedure Code*		Description	
99001		SPECIMEN HANDLING PAT-LAB	
MOD 1	MOD 1 Description	MOD 2	MOD 2 Description
MOD 3	MOD 3 Description	MOD 4	MOD 4 Description
Number of units*			
1 ▼			
This field is required			

Fill out fields for all *Referring*, *RRP Primary Care*, and *Referred To* providers.

Referring Provider Select Facility This field is required Phone* () - -	
RRP Primary Care Provider Select Facility This field is required Phone* () - -	
Referred To Facility Select Facility This field is required Phone* () - -	
Referred To Practitioner Select Practitioner This field is required Phone* () - -	

Indicate whether the *Referred To Practitioner* is authorized to prescribe medications.

When the form is complete, attach supporting documentation and click *Submit*.

Do you authorize the "Referred To Practitioner" above to prescribe medication?*

Comments

Enter any additional comments

Attachments

Supporting documentation (History of present illness, complete admission orders, lab results, emergency department records and other.)

Type

Select Type

File

Choose File No file chosen

Add File

Submit Cancel

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