



Referral Request Form

Date ____/____/____

Phone #: (269) 425-7110
Fax #: (269) 425-7162

PATIENT INFORMATION

BCN ____ Group # _____

BCN Group # [] 280456 [] 281419 [] 282189 [] 283318 [] 284866 [] 288113 [] N/A

Patient Name: _____ Phone: _____

Patient's Contract #: _____ DOB: ____/____/____

PROVIDER/SPECIALTY

Referred BY Provider: _____ Provider NPI #: _____

Referred TO Provider: _____ Provider NPI #: _____

Facility/Hospital: _____ Facility NPI #: _____

REQUESTED SERVICES INFORMATION

Services Start Date ____/____/____ Services End Date: ____/____/____ # of Visits: _____

TYPE OF SERVICE (Circle One): OV OP OPS DME MH ER PT/OT/SPEECH OB IP

Level of Care (Check One): [] Consult Only [] Consult w/Diagnostics [] Global

ICD-10 Code 1): _____ 2): _____ 3): _____ 4): _____

Diagnosis _____

CPT Code 1): _____ 2): _____ 3): _____ 4): _____

Procedure _____

Office Contact: _____ Phone #: _____ Fax #: _____

IHP Office Use Only

Table with 6 columns: #, No Authorization Required, Approved, Denied, Redirected to In-Network Provider, Disagree with Redirection. Each column has a checkbox.

This referral authorization is valid only for the provider and services listed. An additional referral authorization is required if further services other than those indicated above are necessary. Only those health services covered by the policy/plan of the member/covered person/eligible person at the time of services are eligible for reimbursement, even if ordered by a physician.

Referral Type: [] Clinical Review [] Routine Referral

Classification: [] Info Not Received [] Contract Termined [] Benefit Limitation [] Medical Policy [] No PCP Referral [] Benefit Exclusion [] Medical Necessity

[] Preservice Urgent (72 hours) [] Preservice Non-Urgent (14 days) [] Post Service (30 days)

Met decision time frame: [] Yes [] No

Received Date and Time: _____ Completed: _____ Decision Made: _____
Clinical Documentation Requested Date: _____ Clinical Documentation Received Date: _____ Date Provider Notified: _____
IHP Medical Director Review Date: _____ Plan Medical Director Review Date: _____ Date Patient Notified: _____