

(To request OUT-OF-NETWORK referrals, use the OON Referral Form)

Attn. Member: This authorizes the following specialist to forward to your Primary Care Physician medical information to assist with coordination and continuity of your care.

Member Name: _____ **ID#** _____

In-Network Specialist: _____

Reason for Referral: _____

Restrictions: _____

Date Span: _____ **to** _____ **Number of Visits** _____

PCP Name _____

(Print Name)

(Signature)


(Date)

HA/ABCBS PCP Provider #

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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National Provider Identifier# _____

***Specialist should indicate either the BCBS provider # or the NPI # in field 23 on the HCFA 1500 claim form.**

 *Specialty Referral services are subject to member eligibility and the benefits available through the Member's plan, therefore, this referral should not be considered a guarantee of payment.*

IMPORTANT INFORMATION FOR THE PHYSICIAN AND MEMBER

- **SPECIALIST:** Please submit to the referring Primary Care Physician a summary of findings to include diagnosis(es) and test results, medications and other treatment plans to assist in the continuity and coordination of care. **Please contact the PCP if additional referrals are recommended.**
- X-ray and lab results may be available. To avoid duplication, please check with the Primary Care Physician.
- Information regarding this process is available in the Health Advantage Provider Manual or you may contact Customer Service in the Regional Office.
- **OUT-OF-NETWORK REFERRALS REQUIRE REVIEW AND APPROVAL FOR BENEFIT AUTHORIZATION FOR OON REFERRALS, PLEASE USE THE OUT-OF-NETWORK REFERRAL REQUEST FORM**
FAX OUT-OF-NETWORK REQUESTS TO (501)378-6647
- To verify eligibility and benefits, please call the Customer Service # on the Member's ID card. Have the Member's ID # ready.