BlueChoice® HealthPlan
South Carolina
An independent licensee of the Blue Cross and Blue Shield Association

MATERNITY REFERRAL FORM

Maternity Referrals to a Facility or Other Specialist Only

Fax to BlueChoice HealthPlan at 800-610-5685 or 803-714-6463

FROM: ______________________ FAX: ______________________ # Pages (including this one) ________

This form can only be used to authorize prenatal services for patients for whom you have previously submitted a maternity authorization form. If you do not have a maternity authorization for this patient, please send in a maternity authorization request form or call BlueChoice HealthPlan.

Practice's Name: ______________________ Phone: ______________________

Patient's Name: ______________________ ID#: ______________________

REFERRING TO: (Note: This form can **only** be used for contracting providers.)

- ☐ Facility's or Hospital's Name (if applicable): ______________________
- ☐ Referral Provider Group's Name: ______________________ Appointment Date: ______________________
- ☐ Physician's Name: ______________________ Number of Visits: ______________________
- ☐ Diagnosis/ICD9 (if available): ______________________
- ☐ CPT4/Procedure Code(s): ______________________

Service(s) Requested:

- ☐ Amniocentesis
- ☐ Cerclage
- ☐ Chorionic Villus Sampling
- ☐ External Cephalic Version
- ☐ Fetal Monitoring
- ☐ Genetic Consult
- ☐ Lab Work (specify) ______________________
- ☐ Non-Stress Test
- ☐ Ultrasound
- ☐ Other (specify) ______________________

Comments:

**** Please allow 48-72 hours for the return confirmation fax.****

If your request is urgent, please call BlueChoice HealthPlan.