

REFERRAL PARTNER AUTHORIZATION FORM

Please fax this form to Health Care Services **and** to the specialist's office.
BlueChoice HealthPlan Fax: 800-610-5685 or 803-714-6463
Referrals can also be made on our website at BlueChoiceSC.com.

THIS REFERRAL IS VALID ONLY IF THE LISTED SPECIALIST IS A CONTRACTING PHYSICIAN WITH BLUECHOICE HEALTHPLAN, THE SERVICE IS A COVERED BENEFIT AND THE FORM IS FILLED OUT COMPLETELY.

1) Primary Care Physician:

Physician's Name: _____
Practice's Name: _____
Practice's Phone #: _____
Fax #: _____

2) Referred to Contracting BlueChoice HealthPlan Physician:

Specialist's First Name: _____
Specialist's Last Name: _____
Practice's Name: _____

Patient Information

BlueChoice HealthPlan ID#: _____

Name: _____

DOB: _____
Month
Day
Year

3) Type of Referral: (check only one)

- Referral for office visits and office-based services/procedures that do not require prior authorization.
NOTE: Specialist must get prior approval from BlueChoice HealthPlan for any services/procedures that require authorization. Call Health Care Services at 800-950-5387.
- Referral to Emergency Room – Date of Service: _____ Name of Facility: _____

Important Information for Provider and Member:

- Referrals to **all specialists** are good for **six months** and include all medically necessary follow-up visits.
- Services provided to a patient who is no longer enrolled with BlueChoice HealthPlan are not covered.
- BlueChoice HealthPlan is not responsible for payment of non-covered benefits. Please call Member Services at 800-868-2528 for questions concerning benefit coverage.
- Retroactive referrals are not accepted by BlueChoice HealthPlan.
- Physicians should only collect the applicable member copayment, coinsurance and deductible.
- This form may **not** be used for mental health, durable medical equipment (DME), routine vision care, facility referrals, home care services or referrals to non-contracting providers.

4) Diagnosis, Symptoms or Problem: _____

Comments: _____

Physician's Signature (or designee): _____ Date: _____