

To facilitate your request, this form **must** be completed in its entirety. Out of network referrals must be submitted prior to services being rendered.

Patient Information

Patient name	
Patient date of birth	
Patient ID # with prefix	
Patient diagnosis code	
Comorbidities	

Requesting In-Plan Provider Information

Provider name	
Provider specialty	
Provider address	
Provider ID # /NPI/ Tax ID	
Provider phone number	
Designated contact	

Out-of-Plan Provider Information

Provider name	
Provider specialty	
Provider address	
Provider ID # /NPI/ Tax ID	
Provider phone number	
Co-surgeon name	
Co-surgeon address	
Co-surgeon provider ID# / NPI / Tax ID	
Co-surgeon phone number	
Assistant surgeon name	
Assistant surgeon address	
Assistant surgeon provider ID# / NPI / Tax ID	
Assistant surgeon phone number	
Facility name	
Facility address	

Services

Is this out-of-network referral for a surgery or procedure?	Yes	No
If yes, what are the CPT codes?		
Is this out-of-network referral for pre/post-transplant services?	Yes	No
Has the patient seen an in-plan specialist?	Yes	No

Required Documentation

- ✓ Clinical documentation that supports the need for services; include office notes
- ✓ Clinical documentation that supports the need for services to be performed out-of-network
- ✓ Consultation report from an **in-plan specialist** who evaluated the patient for the requested service
- ✓ For requests for additional visits on an approved out-of-network referral, send **current** office notes