

## BlueChoice Referral Form For Primary Care Physician Use Only \*\*Valid for Maximum of 45 Days

**Fax or Mail Referrals ONLY TO:** Blue Cross and Blue Shield of Illinois, 3405 Liberty Drive, Springfield, IL 62704-6547, FAX# 1-800-852-1360

Group #: \_\_\_\_\_ Member #: \_\_\_\_\_ Patient Relationship to Member:  
 Self  Spouse  Child  Other

Patient Name/First:: \_\_\_\_\_ Last:: \_\_\_\_\_ Sex:  M  F Date of Birth: \_\_\_\_\_

Member Name/First: \_\_\_\_\_ Last (if different): \_\_\_\_\_

**Referral From PCP:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

National Provider Identifier (NPI) #: \_\_\_\_\_

Diagnosis (ICD-9)/Symptoms: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

**Referral To BlueChoice Provider:**

Name: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

Referral Place of Treatment:  Office  Outpatient  Inpatient  ER  Home

**THIS REFERRAL AUTHORIZES THE SERVICE(S) INDICATED BELOW FOR THE FOLLOWING DATE(S):**

**BEGINNING** \_\_\_\_\_ **UNTIL** \_\_\_\_\_ **ONLY.**

**Inpatient Care (Pre-Authorization via 1-800-232-3476).**

**Outpatient Consultation**

One Visit

Number of Visits Specify \_\_\_\_\_

PPO Facility: \_\_\_\_\_

X-Ray Specify \_\_\_\_\_

**Procedure\***  
Specify \_\_\_\_\_

**Chemotherapy**

**Obstetrical Care**

Laboratory  
Specify \_\_\_\_\_

MRI (Requires Preauthorization)

**Radiation Therapy**

**Surgery** Specify \_\_\_\_\_

**Other Outpatient Services/Specify:** \_\_\_\_\_

Referring Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PCP authorizes Participating Specialist Physician (PSP) to precertify service(s)

Specialist's Findings and Recommendations: (or attach separate report)

Specialist's Signature: \_\_\_\_\_

**REFERRING RULES**

1. Payment will be made only for the services specifically authorized by this form and covered under the member's benefit plan.
2. Any additional services, including diagnostic procedures or referrals to other consultants, must first be authorized by the referring Primary Physician Caregiver who must complete another referral form for the additional services. Consultant/Facilities must inform the Referring Physician indicated above.
- \*\*3. This referral is valid only for the dates specified above up to a maximum of 45 days unless otherwise specified by the PCP. Payment will not be made for services rendered after that time period.
4. All hospitalizations and procedures must occur in Blue Cross Blue Shield Plan Blue Choice hospitals or facilities unless a waiver has been obtained from the BCBSI Utilization Management Department. To obtain a waiver you must contact 1-800-232-3476.

This referral form does not guarantee payment for those costs that are the patients responsibility (e.g., co-insurance, deductibles, etc.)

\*Depending on procedure, may require pre-authorization via 1-800-232-3476. Please check members benefit plan.