BlueCross BlueShield of Texas

RECORD OF REFERRAL TO SPECIALTY CARE

Today's Date: _____ County: _____

This form is for the use of a Primary Care Physician (PCP) to a referring specialist. Please do not use this form for other care.

Please do not attach this document to the claim form; it is for your records only. For in-network referrals and for services that do not require prior authorization, you do not need to contact BCBSTX for prior authorization. For referrals to out-of-network providers and for services that require prior authorization, please contact BCBSTX for authorization before the services are rendered. Prior authorization for selected services and procedures continue to be required.

PCP Information

Last Name: _____ First Name _____

NPI: _____

Address: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____

Member Information

Last Name: _____ First Name: _____

ID Number: _____ Date of Birth _____

Record of Specialist Visit/Coordination of Care

Specialist Information

Prior Authorization Number *(for out-of-network and/or services requiring prior authorization only):* _____

Last Name: _____ First Name: _____

Address: _____ State: _____ ZIP Code: _____

Specialty: _____ ICD-9 Diagnosis Code: _____

Date of Visit: _____ Diagnosis: _____

Treatment Plan: _____

_____

_____

Follow-up with PCP: _____ Days _____ Weeks _____ Months _____As Needed

All claims presented to BCBSTX for payment are subject to conditions and restrictions including those relating to benefits and eligibility. This is not a promise or guarantee of payment. This form should be placed in the member's file.

www.bcbstx.com

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