**Please email to:** **CONVUM-Wellpoint@WellPoint.com****, or fax to: 1-800-763-3142**

**1**

Date:

**2**

**2a.** Patient Name:       **2b.** Patient ID #:

**2c.** Patient DOB:       **2d.** Reason for Referral (ICD code):

**2e.** CPT code(s):      **2f.** Number of visits:

**3**

***Referring Physician:***

**3a.** Full Name:       **3b.** Telephone:       **3c.** Fax:

**3d.** Provider TIN (tax ID number):

***Specialist being referred to:***

**3e.** Full Name:       **3f.** Specialty:

**3g.** Practice name:       **3h.** Address:

**3i.**  Telephone:       **3j.** Fax:       **3k.** Provider TIN (tax ID) if available:

**4**

**Office Visits:**

**4a.** **[ ]** Initial Office Visit **4b.** **[ ]** Initial Office Visit/Follow Up Treatment

**4c.** Other:

**5**

This referral is not an authorization or guarantee of coverage. By accepting this referral, the provider may be required to accept payment based upon insurer’s applicable fee schedule.

Insurer and PCP must be contacted prior to any hospital admissions.

Insurer will not be responsible for payment of non-covered service(s), even with PCP referral.

Generally, referrals are valid for 3 months from the date on referral form, unless otherwise specified by PCP’s direction. Individual plans may vary.

HMO services without a referral by the PCP are not covered this includes specialist services.

HMO benefits will generally only be paid for Out-of-Plan services with preauthorization by insurer’s Medical Director.

This referral form is for Guided Access HMO and Pathway X HMO members only.

**Please email to:** **CONVUM-Wellpoint@WellPoint.com****, or fax to: 1-800-763-3142**

**INSTRUCTIONS FOR COMPLETION OF THE STANDARD REFERRAL FORM**

1. Date referral written (back date if after date of services)

**2a.** Full name of patient being referred, e.g. John A. Smith, Jr.

**2b.** Patient’s insurance carrier identification number, including alpha prefix YFY01122334400

**2c.** Patient’s date of birth, e.g. 01/02/56

**2d.** Reason for referral (such as diagnosis, e.g. abdominal pain or ICD-9 code)

**2e.** Procedure or CPT code

**2f.** Number of visits to the specialist. Additional visits must be approved by the primary care physician in order for claims to be paid

**3a.** Full name and specialty of referring provider (usually Primary Care Provider)

**3b.** Telephone number of referring provider, including area code, e.g. (702) 321-1234 (\_\_\_) \_\_\_-\_\_\_\_

**3c.**  Fax number of the referring provider

**3d.** Referring provider’s tax identification number

**3e.** Full name of provider that patient is being referred to

**3f.** Specialty of provider that patient is being referred to

**3g.**  Practice name of provider that patient is being referred to

**3h.** Address of specialist

**3i.** Telephone number of provider that patient is being referred to, including area code, e.g. (702) 321-1234 (\_\_\_) \_\_\_ -\_\_\_\_

**3j.** Fax of provider that patient is being referred to

**3k.** Specialist provider’s tax identification number (if available)

**4a.** Type of office visit: Initial Office Visit

**4b.** Type of office visit: Initial Office Visit/Treatment

**4c.** Other information you feel is important