BlueCross BlueShield of Oklahoma

LIMITED COST-SHARING REFERRAL FORM

American Indians and Alaska Natives (AI/ANs) can get treatment from Indian health care providers at Indian Health Service, Tribal and Urban Indian facilities (I/T/Us).

AI/ANs on Health Insurance Marketplace limited cost-sharing plans who need services they cannot obtain through an I/T/U facility can get services at a different provider without paying anything out of pocket, if they have a referral.*

I/T/U facilities should use the following process to submit referrals for Blue Cross and Blue Shield of Oklahoma (BCBSOK) members to cover cost-sharing for medical care that is provided by non I/T/U facilities**:

Medical Referral

I/T/U facility completes a medical referral letter including:

- Referring I/T/U facility Information

  Contact Name _____

  Mailing Address _____

  Telephone # _____

  Physical Address _____

- Patient Information

  Name _____

  Group Number _____

  Member ID Number _____

  DOB _____

- Referral Provider Information

  Name of Provider and/or Facility _____

  Number of Visits _____

  Referral Effective ___ /___ /___ through ___ /___ /___

  Services to be performed: Type of services expected _____

Please fax the referral to our Payment Services Claims Processing area at: 918-549-7777.
Referrals can also be mailed to:

7777 East 42nd Place
Tulsa Oklahoma 74145
Attn: I/T/U Referral

* Members who receive services from an out-of-network provider may incur additional charges.
** For benefit questions, please contact the customer service number on the back of the member's ID card

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Pharmacy Referral

Pharmacy claims are processed when the BCBSOK member fills the prescription at the pharmacy, so **it is important for members to obtain an I/T/U referral before picking up a prescription.*** Members may have to **pay out of pocket** for prescriptions filled without a referral.

I/T/U facility completes a pharmacy referral letter including:

- Referring I/T/U facility Information

  Contact Name _____

  Mailing Address _____

  Telephone #_____

  Physical Address _____

- Patient Information

  Name _____

  Group Number _____

  Member ID Number _____

  DOB _____

- Referral Pharmacy Information

Pharmacy Name and Location/Address _____

Number of Prescriptions needing Cost-Sharing Reduction and Length of Referral: How many medications are needing patient cost-sharing waived? Prescriptions needing cost-sharing reductions can only be set up with a claim on file.

Name of Medication _____ Referral Effective ___ /___ /___ through ___ /___ /___

Name of Medication _____ Referral Effective ___ /___ /___ through ___ /___ /___

Name of Medication _____ Referral Effective ___ /___ /___ through ___ /___ /___

Name of Medication _____ Referral Effective ___ /___ /___ through ___ /___ /___

Name of Medication _____ Referral Effective ___ /___ /___ through ___ /___ /___

Please fax the referral to Pharmacy Services at: 312-946-3880.

Referrals can also be emailed to: **PharmacyServices@bcbsok.com**

* Some prescriptions may need prior authorization. This referral form is not a substitute for that process. For benefit questions, please contact the customer service number on the back of the member's ID card.

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