

BLUELINCS HMO REFERRAL/AUTHORIZATION REQUEST

Precertification Fax Number: 918-549-3048

Please call the Precertification Department for any MRI, Outpatient Surgery, Inpatient Admission or Out-of-Network Referral

DO NOT SEND ANY MEDICAL RECORDS WITH THIS REQUEST

PatientsName _____ BlueLincsID# _____ Group# _____

Date of Request _____ Date of Birth _____

Initial Request _____ OR Extension of Request _____

Date of Service (if known) _____

PCP Name _____ Specialist _____

Phone(_____) _____ Phone(_____) _____

Fax (_____) _____ Fax (_____) _____

Contact Person _____ Contact Person _____

Request from PCP _____ OR Specialist _____

Diagnosis _____ ICD 9 _____

CPT Codes _____

Inpatient _____ Outpatient _____

List Facility, if applicable _____

Please circle your selection below. *If your selection is for a procedure, you must fill in the CPT code.*

1. Consultation and up to two follow-up visits. Date Range of Service: _____

2. Consultation Only. Date of Service: _____

a. _____ (If checked) No follow up allowed without additional PCP Referral

3. Emergency Room Visit: Date _____ Did PCP send? ____ Yes ____ No

4. Obstetrical Care: (due date) _____

5. Durable Medical Equipment: (include HCPCS Code/s) _____

6. Allergy Treatment-testing or serum: *YOU MUST COMPLETE ALLERGY AUTHORIZATION FORM*

7. Diagnostic Procedure: _____

8. *PT, OT, ST, OR HOME HEALTH CARE BENEFIT – ENTER: TREATMENT TYPE and MAX # OF CONSECUTIVE CALENDER DAYS per CONFIRMATION BY CUSTOMER SERVICE* _____

ANY SERVICES NOT LISTED ABOVE, MUST BE PREAUTHORIZED BY BLUE LINCS HMO

FOR BLUELINCS STAFF ONLY

Referral number given by BlueLincs HMO _____ Number of visits approved _____

Authorization expires on _____

Comments _____

This referral does not guarantee payment for services provided. Payment depends upon member eligibility, benefits and participation in the BlueLincs Program. This form WILL NOT be processed unless all necessary information is completed.