

Referral Form

PLEASE COMPLETE ALL APPROPRIATE FIELDS

* Indicates required fields

Member ID#*	Member Last Name*	Member First Name*	Member Date of Birth*
Member Phone*	Member Alternate Last Name (parent/guardian)	Member Alternate First Name	Member Alternate Phone
PCP Group Name*		Passport PCP Group ID Number (Not Tax ID or NPI)*	

Passport Health Plan members and providers please note:

- This referral form may only be used for referral from a PCP to a participating specialist and/or participating Urgent Care Center. Referrals to non-participating providers require prior authorization.
- Passport Health Plan will pay for only those services specifically noted and requested by the PCP, covered under the benefit plan, and be medically necessary.
- Services rendered without a referral will not be covered by Passport Health Plan.
- Specialists cannot refer to other specialists. Additional specialty services must be coordinated by the PCP.
- Referral by the PCP does not guarantee payment.
- Please refer to the Provider Manual for information on services that do not require a referral.

This member is being referred to: (THE FOLLOWING INFORMATION IS REQUIRED.)

Please use group or facility name/ID unless provider is a sole practitioner.

Referred to Provider Name*	Referred to Passport Provider ID# or NPI or group ID#*	Specialty Type*
Street Address*	City*	Zip Code*
Diagnosis and ICD-9 Code (Please provide all available diagnoses)*		Is this referral related to an EPSDT screen?*
		<input type="checkbox"/> Yes <input type="checkbox"/> No

The PCP must check ONE large box and one small box:*

- Referral for CONSULTATION, DIAGNOSTIC STUDIES and TREATMENT.
Good for unlimited visits within: 3 months, 6 months, 9 months, 12 months
- Referral for CONSULTATION, DIAGNOSTIC STUDIES and TREATMENT.
Number of visits approved: 1 visit, 2 visits, 3 visits, 4 visits, 5 visits, 6 visits
- Referral for CONSULTATION and DIAGNOSTIC STUDIES.
Number of visits approved: 1 visit, 2 visits, 3 visits, 4 visits, 5 visits, 6 visits
- Referral for CONSULTATION only (second opinion). PCP must forward all lab/xrays, etc.
- Unlimited referrals for cancer diagnosis and transplants.
- Referral for urgent care services at an Urgent Care Center administered on _____.
(Must be issued within five [5] business days of the service.)

Authorizing Signature (required)* X _____	Date*
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Send a copy of this completed form to: Passport Health Plan PO Box 7114 London, KY 40742	Questions? Call Provider Services at 800-578-0775
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Please provide a copy of this referral to the specialist and member.