PASSPORT HEALTH PLAN

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*		Group NPI*	Tax ID

Passport Health Plan members and providers please note:

- Referrals are valid for one (1) year with unlimited visits.
- For electronic referral submissions, please visit the Passport Provider Portal at https://phkyportal.valence.care/
- 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*	Group NPI*	Tax ID	Specialty Type*
Street Address*	City*		Zip Code*
Diagnosis and ICD-10 Code (Please provide all available diagnoses)*		Is this referral related to an EPSDT screen?*	❑ Yes ❑ No
Authorizing Signature (required)* **X** _____		Date*	
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	

Please provide a copy of this referral to the specialist and member.