Referral Form

Effective 1/1/04, primary care physicians need only request an initial referral to a participating specialty physician. The referral will be "open-ended"; i.e., the PCP will not need to call in again to extend or renew the referral.

- PCPs may still limit the referral by specifying a referral duration.

- This new policy does not apply to referrals for podiatry or dermatology. For those specialties, PCPs must specify a referral duration. If they do not, the referral will be for 3 months.

- This policy does not apply to behavioral health referrals. The duration of those referrals are determined by the Behavioral Health Department.

- Providers must supply referral information to the Plan on or before the date the member is to receive the specified care.

- Referrals to non-participating specialists require pre-authorization. Fax a Letter of Medical Necessity to (716) 857-6361 or 1(800) 465-1373

- Payment of a claim is contingent upon medical necessity and the member's eligibility and benefits on the date of service.

- The Plan reserves the right to deny claims submitted more than 90 days after the date of service.

- PCPs or referring specialists must notify the Plan of inpatient admissions by calling (716) 857-4500 or 1(800) 610-1113.

Select one:  ❑ New Patient  ❑ Existing Patient

Expeditex?  ❑ Yes  ❑ No

Today’s Date: _____________  Referral Number (for internal use): _______________

Referring Physician ID Number: ____________________________

Referring Physician Name: ________________________________

Referring Physician Fax Number: __________________________

Member ID Number: ______________________________________

Member Name: __________________________________________

Primary Diagnosis Code: _________________________________

Date of Onset (if known): __________________________________

If applicable, please indicate if there is other insurance (select one):

☐ Worker's Compensation  ☐ No-Fault Insurance  ☐ Other____________

Date of Injury: __________________________________________

Specialist Name: _________________________________________

   last     first     middle initial

Specialty: ________________________________________________

Referral Start Date: _________________________________

Referral Duration  (Select one. If no option is checked, the referral will be open-ended except for podiatry, dermatology, or behavioral health. For those specialties, the default referral will be 3 months.)

☐ Open-ended  ☐ 1 month  ☐ 3 months  ☐ 6 months  ☐ 12 months

The referring physician authorizes this specialist to provide the following care to this patient:

☐ Consultation, excluding diagnostic testing and treatment (one visit).

☐ Consultation with diagnostic testing, excluding treatment (one visit).

☐ Consultation, diagnostic testing, and treatment, excluding authorization to admit this patient.

☐ Consultation, diagnostic testing, treatment, and authorization to admit this patient. (Providers must notify the Plan at (716) 857-4500 or 1(800) 610-1113 prior to any inpatient admission.)

☐ Extend existing referral to specialist. Enter referral number_____________________

☐ Second opinion, excluding treatment (one visit).

Phone, fax, or mail this referral to:  Referral Services

205 Park Club Lane

Buffalo, NY 14221

Phone: (716) 857-4500 or 1(800) 610-1113

Fax: (716) 857-4694 or 1(800) 245-3370