Uniform Consultation Referral Form

CareFirst
Family of health care plans

1. PATIENT INFORMATION		2. CARRIER INFORMATION
Date of Referral		Carrier Name (check one) ◯ CareFirst BlueChoice ◯ CareFirst BlueCross BlueShield
Name (Last, First, MI)		
Date of Birth	Phone #	Referral # RE0000001
ID #	Site #	

3. PRIMARY OR REQUESTING PROVIDER		
Name (Last, First, MI)		Specialty
Institution/Group Name	Provider ID	Provider ID #2 (if required)
Address (Street, City, State, Zip)		
Phone #	Facsimile/Data #	

4. CONSULTANT/FACILITY PROVIDER		
Name (Last, First, MI)		Specialty
Institution/Group Name	Provider ID	Provider ID #2 (if required)
Address (Street, City, State, Zip)		
Phone #	Facsimile/Data #	

5. REFERRAL INFORMATION
Reason for Referral
Brief History, Diagnosis and Test Results

6. SERVICE DESIRED (PROVIDE CARE AS INDICATED)	7. PLACE OF SERVICE
◯ Initial Consultation Only ◯ Diagnosis Test (specify) _____ ◯ Consultation With Specific Procedures (specify) _____ ◯ Specific Treatment ◯ Global OB Care & Delivery ◯ Other (explain) _____	◯ Office ◯ Outpatient Medical/Surgical Center* ◯ Radiology ◯ Laboratory ◯ Inpatient Hospital* ◯ Extended Care Facility* ◯ Other (explain) _____ *(Specific facility must be named)

Number of Visits (If blank, 3 visits are assumed)	Authorization # (If required)	Referral is Valid Until (Date) *(See carrier instructions)
Signature (individual completing this form)		Authorizing Signature (if required)

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan/carrier.

General Information

1. Do not complete shaded area of this form.
2. A written referral issued by the primary care physician (PCP) is not a guarantee of benefits. Benefits are available only if the member is eligible at the time services are rendered. Benefits may be subject to contractual exclusions.
3. This referral does not authorize payment to non-participating physicians or providers. Services by non-participating providers cannot be authorized by a primary care physician and require prior approval.
4. This referral is for services rendered only in a provider's office. Authorization from CareFirst BlueChoice is required for all hospital admissions, hospital-based outpatient/ambulatory services, durable medical equipment and for all services rendered in a setting other than the provider's office. For authorization, the prescribing physician/hospital (depending on the service) must call 1-866-Pre-Auth.
5. Services must be rendered within 120 days from the date of the referral and are good for a maximum of three (3) visits unless otherwise indicated. If the number of visits is not indicated, the referral will default to three (3) visits and 120 days.
6. The exceptions to the three (3) visit maximum are referrals for allergy, immunology, oncology, hematology and pediatric hematology/oncology and any other qualifying service. Long standing referrals for these services may be valid for up to one year or longer.
7. A referral from the PCP is not necessary for OB/GYN care.

PCP Instructions (For the HealthyBlue product only)

1. Complete all required sections of the form as follows:

   Section 1—Patient Information—Complete all fields except phone and site Number.

   Section 2—Carrier Information—Circle the correct carrier name.

   Section 3—Primary or Requesting Provider—Complete name, provider ID (your 8-digit CareFirst BlueChoice ID), and phone number.

   Section 4—Consultant/Facility Provider—Complete name, provider ID (specialist's 8-digit CareFirst BlueChoice ID), and phone number.

   Section 5—Referral Information—Complete reason for referral.

   Section 6—Services Desired—Complete number of visits. Will default to three (3) visits if left blank.

   Section 7—Place of Service—Place X in the "Office" checkbox only. Complete the referral is valid until (date) and the authorizing signature boxes.

2. Keep a copy of this form for your records. Copy and give the member two (2) copies and inform the member that one (1) copy should be given to the specialist.
3. Submit the completed Uniform Consultation Referral Form to CareFirst BlueChoice (applies to PCP only) by fax to 410-505-6160 or 1-800-354-8205. Forms can also be mailed to: Mail Administrator, P.O. Box 14116, Lexington, KY 40512-4116.
4. This is not the correct form to refer a member for laboratory or radiology services. Laboratory services should be on a LabCorp requisition form. When directing members to an approved radiology facility, complete an order on the physician's letterhead or prescription pad.

PCP Instructions (Applies to all BlueChoice products except HealthyBlue)

1. Complete all required sections of the form as follows:

   Section 1—Patient Information—Complete all fields except phone and site number. Include the alpha-numeric prefix as it appears on the member's ID card.

   Section 2—Carrier Information—Circle the correct carrier name.

   Section 3—Primary or Requesting Provider—Complete name, provider ID (your 8-digit CareFirst BlueChoice ID), and phone number.

   Section 4—Consultant/Facility Provider—Complete name, provider ID (specialist's 8-digit CareFirst BlueChoice ID), and phone number.

   Section 5—Referral Information—Complete reason for referral.

   Section 6—Services Desired—Complete number of visits. Will default to three (3) visits if left blank.

   Section 7—Place of Service—Place X in the "office" checkbox only. Complete the referral is valid until (date) and the authorizing signature boxes.

2. Keep a copy of this form for your records. Copy and give the member two (2) copies and inform the member that one (1) copy should be given to the specialist. The specialist is responsible for including the referral informatiown on the member's claim form.
3. Do not mail completed Uniform Consultation Referral Form to CareFirst BlueChoice (applies to PCP only).
4. This is not the correct form to refer a member for laboratory or radiology services. Laboratory services should be on a LabCorp requisition form. When directing members to an approved radiology facility, complete an order on the physician's letterhead or prescription pad.

Patient Instructions

1. Give a copy of the Uniform Consultation Referral Form to the specialist.
2. Keep a copy for your records.

Specialist Instructions

The following referral instruction is required when submitting your claim electronically or on paper.

On Paper CMS 1500 forms:

Block 17—Enter the PCP's first and last name

Block 17A—Enter the PCP Number (four digit group number + four digit member number)

Block 19—Enter the Date of the Referral (MM/DD/YY) and the Number of Visits indicated on the referral (1, 2, 3, etc.)

Block 23—Enter the Referral Number (RE0000001)

Your electronic vendor has information on how to submit this information electronically. Please contact your electronic vendor if you have questions.

Important Note for the HealthyBlue Product: The PCP will complete the entire referral process. Specialists should only perform the services listed on the referral form.