



Date: _____

Referral #: _____

Member Information

Referring Physician Information

Name: _____

Name: _____

Date of Birth: _____ ID#: _____

Phone: (____) _____ Fax: (____) _____

Phone: (____) _____

Contact Person: _____ Ext. _____

Referred To

Medical_Oncology/Hematology Radiation Oncology (Circle one. Must be a par provider)

Name: _____

Phone: (____) _____ Fax: (____) _____

Address: _____

Tax ID#: _____

Diagnosis: _____ Description: _____

Office Visit x _____ visit(s)

COMMENTS OR ADDITIONAL CODES:

Note to receiving Provider/Facility: This referral form is only for medical oncology, hematology and radiation oncology. If you are a non-participating provider, Inpatient Facility or Outpatient Hospital provider an authorization is required for your services. This is not an authorization form and payment is therefore not guaranteed. If you have any questions please call Utilization Management (888) 978-0940.

Instructions: (This form is for referral to the following only)

- **Participating specialists** for office visit and treatments in the office that do not require pre-certification.

One copy to patient's chart and one copy to the Provider and one copy faxed to Plan