TRUST PREFERRED PROVIDER ORGANIZATION (PPO) and POINT OF SERVICE (POS) PROGRAM REFERRAL FORM

Dear PPO or POS Member:

Your PPO or POS practitioner, facility or laboratory has completed this form because you are being referred for services to a non-PPO or non-POS practitioner, facility, ancillary provider or laboratory.

Referrals outside the PPO or POS networks are required when covered services are medically necessary and not reasonably available within the designated network (the TRUST network for PPO members and the POS network for POS members). When these conditions are met, **out-of-network** cost sharing (deductibles and copays) are not applied. However, if your contract has **in-network** deductibles and copays, you will still be responsible for those.

Referrals are only valid up to **60 days** after the date of the referral. The referral covers services that are performed within one year of the date of the referral. Retroactive referrals **will not** be approved without documentation in your medical record.

Benefits are not covered when members are referred to non-approved BCBSM facilities — for example, non-approved outpatient mental health, and outpatient physical therapy facilities.

If you are referred to a practitioner, facility, ancillary provider or laboratory that does not participate in any BCBSM product (PPO, POS or Traditional), you may be responsible for paying the provider charges that exceed the BCBSM payment.

Note: referrals for MESSA Tri Med members **must** be made by the member's assigned Primary Care Physician.

TO BE COMPLETED BY REFERRING PRACTITIONER/FACILITY/LABORATORY

Date of Referral	Month	Day	Year	If needed, Date of Revised Referral	Month	Day	Year	Contract Number

Subscriber Name	Member's Last Name	Member's First Name	Date of Birth

Non-PPO/POS Practitioner/Facility/Lab Name	Address	City	State	Zip Code	Telephone

Referring PPO/POS Practitioner/Facility/Lab Name	Address	City

State	Zip Code	Telephone	**Referring Practitioner or Laboratory** Record digits 3 through 9 of your 10 digit BCBSM PIN	**Referring Facility** Record your 5 digit BCBSM Facility code

Referring Practitioner's License Number	Record all 10 digits of your National Provider Identifier	Record all 10 digits of your National Provider Identifier

Reason For Referral

Anticipated Start Date	Month	Day	Year	Number of Visits	Length of Treatment

TO BE COMPLETED BY REFERRED PRACTITIONER/FACILITY/ANCILLARY PROVIDER/LABORATORY

Location: ☐ Practitioner's Office ☐ Outpatient Facility ☐ Inpatient Facility ☐ Independent Laboratory

Date of Service/Start Date	Month	Day	Year	End Date	Month	Day	Year	Specific Services Requested

ICD-9 Diagnosis (Code & Description)

All signatures are required for this form to be valid.

Signature of Patient or Authorized Person ____ Date ____

Signature of PPO or POS Referring Practitioner/Facility/Laboratory ____ Date ____

Signature of NON-PPO or NON-POS Practitoner/Facility/Ancillary Provider/Laboratory ____ Date ____

INSTRUCTIONS

If hospitalization is necessary, please inform the referring PPO or POS practitioner immediately and request a new referral.

Referred provider: Return the white copy to the PPO or POS referring practitioner. Give the pink copy to the member. Retain the yellow copy in the patient's record.

If submitting paper claims:

Professional provider: Record the PPO or POS referring practitioner/laboratory seven-digit PIN in field 10D of the CMS-1500 claim. Attach the yellow copy of this form to the claim.

Facility provider: Record the PPO or POS referring practitioner/facility/laboratory PIN in the "Treatment authorization" field of the UB-04 claim. Attach the yellow copy of this form to the claim.

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