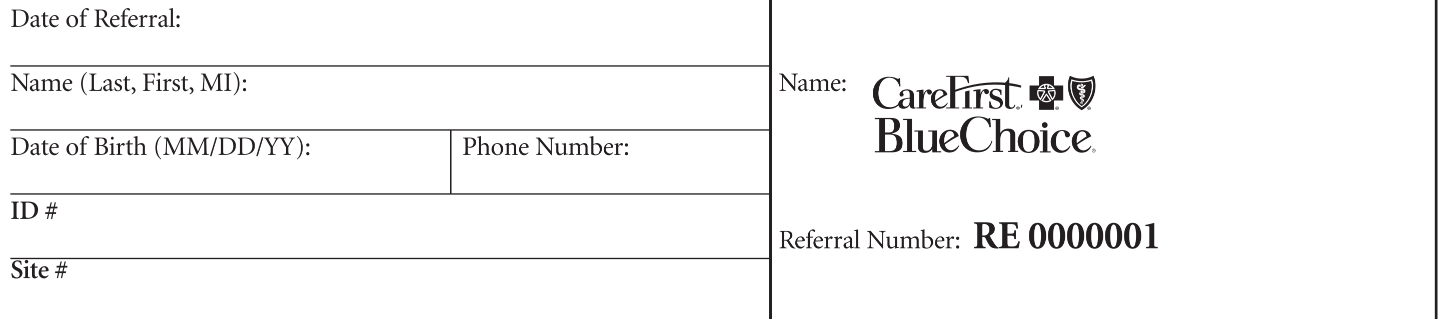
Uniform Consultation Referral Form

Please do not mail completed Uniform Consultation Referral Form to CareFirst BlueChoice. Please refer to the important instructions on page 2.

1. Patient Information:

2. Carrier Information



Date of Referral:

Name (Last, First, MI):

Date of Birth (MM/DD/YY): | Phone Number:

ID #

Site #

Name: CareFirst BlueChoice

Referral Number: **RE 0000001**

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 Number: ( ) | Facsimile/Data Number: ( )

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 Number: ( ) | Facsimile/Data Number: ( )

5. Referral Information:

Reason for Referral:

Brief History, Diagnosis and Test Results:

6. Service Desired:

Provide care as indicated:

- ❑ Initial Consultation Only
- ❑ Diagnosis Test (specify): ____________________
- ❑ Consultation With Specific Procedures (specify): ____________________
- ❑ Specific Treatment: ____________________
- ❑ Global OB Care & Delivery
- ❑ Other (explain): ____________________

Number of Visits: *(if blank, 3 visits are assumed)* | Authorization # (if required):

Signature (individual completing this form):

7. Place of Service:

- ❑ Office
- ❑ Outpatient Medical/Surgical Center*
- ❑ Radiology
- ❑ Laboratory
- ❑ Inpatient Hospital*
- ❑ Extended Care Facility*
- ❑ Other (explain): ____________________

**(specific facility must be named)*

Referral is Valid Until (Date):
(see Carrier Instructions)

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.

SEE IMPORTANT INSTRUCTIONS ON PAGE 2

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Form Instructions

General Information

1. Do not complete shaded area of this form.
2. **A written referral issued by the primary care physician 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 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

1. Complete all required sections of the form as follows:
   - Section 1 – **Patient Information -** Complete all fields except Phone and Site #.
   - 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 2 copies and inform the member that one copy should be given to the specialist. The specialist is responsible for including the referral information on the member's claim form.
3. Do not mail completed Uniform Consultation Referral Forms 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.