Request Form

Out of Network Referral

Patient's Name: ______________________ DOB: __________ ID# ______________

Referring Provider: ______________________ Tax ID: __________ Fax#: ______________
Name/Clinic

Refer to Provider: ______________________ Tax ID: __________ NPI: ______________
Name/Specialty/Clinic

Phone: ______________________ Fax: ______________________

Diagnosis: ______________________ ICD-10: ______________

Please indicate the reason for requesting this out of practice group or out of network referral (Please Select One):

- ☐ Specialty not available within the Cooperative's network of contracted providers.
- ☐ Patient has been under the care of this physician for ____ years for this diagnosis.
- ☐ Other – Please specify: ______________________

Please send clinical information to assist in the decision for the need of this referral. This referral request is limited to one of the following and will expire on: _________ (Request cannot exceed greater than 90 days from the date signed below)

Projected Appointment Date: ______________________

Please select one:

- ☐ Surgical consult only one visit:
- ☐ Evaluation and recommendations to the Primary Clinician One visit only
- ☐ Consultation and Treatment of the specific condition listed above as needed and limited to ______ visits. (Indicate number of visits.)
- ☐ Surgical follow up as needed and limited to ________ visits (Indicate number of visits.)
- ☐ Renewal for extended Medical Management of the indicated diagnosis as above and limited to ______ visits. (Indicate number of visits.)

Please indicate if any of the following is suspected to be a cause of the indicated need for the medication:

☐ MVA ☐ Liability ☐ Workers' Compensation ☐ Indicate if this is an emergent request

Please note: In the case of an emergent medical need for a service event authorized service, a service event request with clinical justification of the emergent need must be faxed to the Health Management Department as soon as possible before the services are performed. Please indicate on your request the need for an emergent review.

______________________ ______________ ______________ ______________
Provider Contact Name Phone # Fax # Date

Please refer to the Provider Manual for specific information regarding our network referrals.

Privacy and Confidentiality:
The information within this fax message is intended for the recipient(s) only. If you have received this fax in error, please contact us at (715) 552-4300 and destroy this document received. State and Federal Law prohibits any unauthorized use of this information. Thank you for your cooperation.