

**Record of Referral to Specialty Care**

Today's Date: \_\_\_\_\_ County: \_\_\_\_\_

BlueChoice HealthPlan, as required by the state of South Carolina Department of Health and Human Services (SCDHHS), requires written evidence of communication between referring physician and specialty care provider or continued communication of patient information between the primary care provider (PCP).

For in-network referrals and for services that do not require prior authorization, you do not need to contact BlueChoice HealthPlan for prior authorization. For referrals to out-of-network providers and services that require prior authorization, please contact BlueChoice HealthPlan for authorization before the services are rendered. Prior authorization for selected services and procedures continue to be required.

Please file the completed with the member's medical record. **Do not attach this document to the claim form, it is for your records only.**

**This form is for the use of a PCP to a referring specialist. Please do not use this form for other care.**

**PCP Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Member Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

ID Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Record of Specialist Visit/Coordination of Care - Specialist Information**

Prior Authorization Number (for out-of-network and/or services requiring prior authorization only): \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Specialty: \_\_\_\_\_ ICD-9 Diagnosis Code: \_\_\_\_\_

Date of Visit: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Treatment Plan: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Follow-up with PCP: \_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ As Needed

All claims presented to BlueChoice HealthPlan for payment are subject to the conditions and restrictions including those relating to benefits and eligibility. This is not a promise or guarantee of payment. This form should be placed in the member's chart.

Reminder: Please ensure all pediatric patients are up to date on their immunizations.