PREMERA | BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

CLEAR FORM

Referral Request Form

For Primary Care Provider In-Plan Referral Request for Medicare Advantage Members

Submit requests to:

www.premera.com/wa/provider/medicare-advantage

Fax: 866-809-1370

Phone: 855-339-8127

1. Member Information & Background

Date of referral request: _____

Patient's name: _____

Date of birth: _____

Patient ID #: _____

Primary care provider name: _____

Contact name: _____

Contact phone #: _____ Fax #: _____

☐ New referral

☐ Update of existing referral*

*Referral #: _____

*Update details:

2. Request Information

☐ Office visit

Specialist provider name: _____

Provider specialty: _____

Specialty provider address: _____

_____

Number of visits requested: _____

Date span requested:

_____ - _____

ICD-10 codes: _____