Blue Cross Blue Shield of Rhode Island

Referral Form

Date: ____ / ____ / ____

Patient's Name:_____

Patient's ID #: _____Patient's DOB: _____ / _____ / ____

Patient's Insurance Type: ☐ BlueCHiP plans
☐ All other Blue Cross & Blue Shield of Rhode Island (BCBSRI) plans

Referring Provider's Name: _____

Address: _____

Telephone #:_____Fax #:_____

☐ Referring provider's NPI number: _____
(Specialists – Please use box 17b when filing a claim.)

Referred to: _____

Address: _____

Telephone #: _____ Fax #:_____

Referral Valid From: _____ / _____ / _____ to _____ / _____ / _____
(Note: Number of visits cannot be specified.)

Patient is being referred for:

☐ Consultation only

☐ Consultation and treatment

☐ Treatment only

If you are referring a New England Health Plan (NEHP) patient out of state, please fax this completed form to BCBSRI Health Services Management at (401) 272-8885. NEHP referrals require the appropriate ICD-9-CM diagnosis code.

Please List Code(s) _____

Reason for Referral: _____

_____

Diagnostic Tests/Procedures Requested: _____

_____

Note: Communication is required between PCP and specialist.
PCP's preferred mode of communication is: ☐ Telephone ☐ Fax ☐ Mail