TRUST PREFERRED PROVIDER ORGANIZATION (PPO) PROGRAM REFERRAL FORM

Dear PPO Member:

Your PPO practitioner, facility or laboratory has completed this form because you are being referred for services to a non-PPO practitioner, facility, ancillary provider or laboratory.

Referrals outside the PPO network are required when covered services are medically necessary and not reasonably available within the TRUST network for PPO members. When these conditions are met, out-of-network cost sharing (deductibles and copays) are not applied. However, if your contract has in-network deductibles, coinsurance or copays, you will still be responsible for those.

Referrals are only valid up to 60 days after the date of the referral. The referral covers services that are performed within one year of the date of the referral. Retroactive referrals will not be approved without documentation in your medical record.

Benefits are not covered when members are referred to non-approved BCBSM facilities — for example, non-approved outpatient mental health.

If you are referred to a practitioner, facility, ancillary provider or laboratory that does not participate in any BCBSM Network (PPO, or Traditional), you may be responsible for paying the provider charges that exceed the BCBSM payment.

TO BE COMPLETED BY REFERRING PRACTITIONER/FACILITY/LABORATORY

Date of referral *(mm/dd/yyyy)*	Date of revised referral *(if needed)*	Contract number	
Subscriber name	Patient's last name	Patient's first name	Date of birth
Non-PPO practitioner/facility/lab name			
Address	City	State / ZIP code	Telephone
Referring PPO practitioner/facility/lab name		Record all 10 digits of your National Provider Identifier	
Address	City	State / ZIP code	Telephone
Referring practitioner or laboratory *(Record digits 3 through 9 of your 10 digit BCBSM PIN)*		Referring practitioner's license number	
Reason for referral			
Anticipated date of service/Start date	Number of visits	Length of treatment	

All signatures are required for this form to be valid.

Signature of referring PPO practitioner/facility/laboratory	Date

TO BE COMPLETED BY REFERRED PRACTITIONER/FACILITY/ANCILLARY PROVIDER/LABORATORY

Location: Practitioner's office Outpatient facility Inpatient facility Independent laboratory

Date of service/Start date	End date	Specific services requested
ICD-10 diagnosis (code & description)		
Record all 10 digits of National Provider Identifier for referred practitioner		Referred practitioner's tax ID number

All signatures are required for this form to be valid.

Signature of patient or authorized person	Date
Signature of Non-PPO practitioner/facility/ancillary provider/laboratory	Date

If hospitalization is necessary, please inform the referring PPO practitioner immediately and request a new referral.

Referred provider: Return the white copy to the PPO referring practitioner. Give the pink copy to the member. Retain the yellow copy in the patient's record.

If submitting paper claims:

Professional provider: Record the PPO referring practitioner/laboratory seven-digit PIN in field 10D and the 10-digit NPI in field 17b of the CMS-1500 claim. Attach the yellow copy of this form to the claim.

Facility provider: Record the PPO referring practitioner/facility/laboratory PIN in the "Treatment authorization" field and record the 10-digit NPI in field 56 on the UB-04 claim. Attach the yellow copy of this form to the claim.

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