blue of california

Out of Network Referral Request Form

Please mark applicable criteria below in order to submit:

- ☐ There are no network providers/facilities within 30 miles of the member's home.
- ☐ The member's network provider is unable to perform the necessary service and is forced to refer to an out-of-network specialist/facility.
- ☐ There are significant scheduling barriers whereby the member is unable to make an appointment in a timely manner with a network provider.

Servicing Provider Information	Patient Information
Provider's Name and Address:	Patient's Name:
Provider's Tax ID/NPI Number:	Blue Shield ID Number:
Office Contact:	Birth Date:
Phone: Fax:	Diagnosis ICD-10 code(s):
If servicing provider is not contracted with Blue Shield of California, is the provider willing to negotiate fees to lower members out of pocket expense? (Y/N)	Procedure(CPT)/Service:
If yes, contact name for negotiation: Phone: Fax:	Date of next scheduled visit/treatment:
Facility Information (if applicable)	**Referring Provider/PCP (if patient has not seen requesting provider)**
Facility's Name and Address:	Provider's Name and Address:
Facility's Tax ID/NPI Number:	Provider's Tax ID/NPI Number:
Facility's Contact:	Provider's Contact:
Phone: Fax:	Phone: Fax:
If facility is not contracted with Blue Shield of California, is the facility willing to negotiate fees to lower members out of pocket expense? (Y/N)	
If yes, contact name for negotiation: Phone: Fax:	

INFORMATION REQUIRED BELOW

- **Please include all clinical information pertaining to this request.**
- **If the physician has seen this patient previously please submit clinical documentation with ongoing treatment plan.**

Please fax to BSC: 855-895-3506 | **Phone Number: 1-800-541-6652 Option 6**

Revised: 8/8/2016 Effective: 10/28/2014