Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

U.P. Blue Referral Form

Upper Peninsula BLUE PPO

Section A: Patient Information

1. Patient Name (First and Last)		2. Patient DOB	3. Patient City of Residence
4. Subscriber Name (First and Last)	5. BCBSM Group Number	6. BCBSM Contract Number	7. Policyholder's Employer

Note: Please include a copy of the Subscriber's Blue Cross member ID card

Section B: Referring Michigan PPO Physician Information

1. Referring Physician	2. Specialty	3. Phone Number	4. Fax Number
5. Address	6. City	7. State	8. ZIP Code

9. Referring Physician License Number	10. Digits 3 through 9 of Referring Physician BCBSM PIN	11. Referring Physician 10 digit NPI

12. Michigan PPO Physician Signature	**13. Date**

Section C: Out-of-State/Network Physician/Laboratory/Facility Information

1. Out-of-State/Network Provider/Facility/Laboratory Name	2. Specialty	3. Phone Number	4. Fax Number
5. Address	6. City	7. State	8. ZIP Code

Section D: Reason for Referral

1. What services are being requested?			2. Diagnosis Code(s) (code and description)
3. Anticipated Start Date month/day/year / /	4. Anticipated End Date / /	5. Number of Visits	6. Length of Treatment

7. Why are you referring out-of-state/network?

☐ No PPO In-State Provider Available ☐ PPO In-State Provider unable to schedule in timely manner

☐ Other: (explain) _____

_____

Once completed, please FAX this form and necessary documentation to 906 225-9268

Section E: Determination

Upper Peninsula Health Plan Use

☐ Able to waive out-of-network cost sharing requirements

☐ Unable to waive out-of-network cost sharing requirements

☐ Unable to process due to: ☐ Incomplete Form: Section:___ Number:___; Section:___ Number:___; Section:___; Number:___

☐ Other: _____

Signature _____ Date _____

Not a guarantee of payment. Payment is subject to eligibility and benefit determination.

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Instructions for Completing the UP Blue and Custom UP Blue Referral Form

Please fill out this form completely as your referral cannot be processed without the requested information.

Section A: Patient Information. This section asks for patient information. The Patient's city of residence is necessary so that the distance to the referred provider may be calculated from their home. The ENTIRE BCBSM Contract and Group Numbers are required. These numbers allow the processor to determine your patient's UP Blue or Custom UP Blue Plan Benefit. Additionally, please list the name of the policyholder's employer

Section B: Referring Michigan PPO Physician Information. This section is asking for the referring PPO Physician's information and must be completed so that BCBSM can authorize the Out-of-State or Out of Network request. Please include the Specialty such as "Cardiologist" or subspecialist such as "Pediatric Cardiologist". BCBSM also requires the Physician's License Number, BCBSM Pin Number, and NPI number in order to complete the waiver process. Lastly, the **Referring Physician must sign and date this form.**

Section C: Out-of-State/Network Physician/Laboratory/Facility Information. This section is requesting contact and identifying information for the Physician, Facility, or Lab to whom you are referring your patient. Please complete all 8 areas of this section.

Section D: Reason for Referral. Please indicate the specific services requested such as "evaluation by an endocrinologist". Include a diagnosis code and description as well as a date range of anticipated treatment and the number or frequency of visits requested. Check the box that best describes the reason for the Out-of-State/Network referral.

Section E: Determination. The UP Blue Processor will complete this section and fax this form back to you, the provider. If the Request was not processed, please complete the missing fields as indicated or include the specific requested information, and re-send the form. BCBSM will send a letter to the member to communicate the final outcome. Please note that reconsideration is only possible if additional information is submitted with a new referral.

FAX completed form and necessary documentation to 906-225-9268 for review