

Rapid Referral Notification

Fax: 515-376-9017
 Address: Wellmark Rapid Referrals
 Mail Station 5W195
 PO Box 9232
 Des Moines, Iowa 50306-9232

Referrals must be faxed or mailed using the fax number or address given above to ensure appropriate and timely processing. This form must be completed in full or it may be returned to you for completion.

<p><u>Internal Use Only</u></p> <hr/> <p>Member ID #: _____</p> <p>Patient Name: _____</p> <p>Date of Birth: _____ Sex: M / F</p> <p>Patient Phone Number _____</p> <p>Patient Address: _____</p> <p>_____</p> <p>Plan: <input type="checkbox"/> Blue Advantage[®] <input type="checkbox"/> Blue Choice[®] <small>(check one)</small> <input type="checkbox"/> Blue Access[®]</p> <hr/> <p>ICD-9 Diagnosis: _____</p> <p>Narrative: _____</p> <p>_____</p> <p>PCP is requesting the following services:</p> <p><input type="checkbox"/> Consult Only</p> <p><input type="checkbox"/> Consult with Diagnostic Testing</p> <p><input type="checkbox"/> All of the Above Including Medical Treatment</p> <p><input type="checkbox"/> All of the Above including Surgical Services</p> <p><input type="checkbox"/> Physical Therapy <input type="checkbox"/> Speech Therapy</p> <p><input type="checkbox"/> Home Health <input type="checkbox"/> Hospice <input type="checkbox"/> Home Infusion</p> <p><input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Dialysis</p> <p><input type="checkbox"/> Medical Equipment (Description/HCP/CS)</p> <p><input type="checkbox"/> Chiropractor</p> <p><input type="checkbox"/> Facility</p> <p>_____</p> <p>_____</p> <p><i>(If not complete, we will assume the request is for unlimited services.)</i></p>	<p>Primary Care Physician Name: _____</p> <hr/> <p>PCP Office Address: _____</p> <p>_____</p> <p>_____</p> <p>PCP Office Contact: _____</p> <p>PCP Telephone Number: _____</p> <p>PCP Fax Number: _____</p> <p>PCP NPI _____</p> <p>PCP Signature and Date: _____</p> <hr/> <p>Referred To: <i>(Complete Name and Address)</i></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Telephone Number: _____</p> <p>Fax Number: _____</p> <hr/> <p>Facility: _____</p> <p>_____</p> <hr/> <p>Referral Duration Dates:</p> <p>From: _____ To: _____</p> <p>Number of Visits: _____</p> <p><i>(If not complete, we will assume unlimited visits for six months.)</i></p>
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All services must be provided by IN NETWORK providers, including the facility. Please refer to the appropriate Plan Directory.

Attention Specialists: Please contact the PCP for any additional services required that are not authorized above and communicate outcomes.

This referral is valid only for the specialist or office listed. Secondary consultations and follow-up appointments require referral from the PCP. Without appropriate approval for out of network care, member is responsible for charges. Retrospective authorization is not valid. This is NOT a benefit determination or a guarantee that benefits are available.

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