Managed Care Referral Fax Form

ONLY use this form if referring to a non-par provider. *Submit referrals using the Availity Portal.*
For submission questions, reference the training demo at www.Availity.com or contact Availity directly.

BCBSMN, Inc. and Affiliates
P.O. Box 64179
ST. Paul, MN 55164-0179
Telephone (651) 662-5200 or 1-800-262-0820
Fax (651) 662-6860 (use only one side of form)

From:

Primary Care Referral Contact Name _____ Date _____

Phone (_____) _____ FAX (_____) _____

Primary Care Clinic Information:

Patient's Primary Care Clinic Name _____ Primary Care Clinic NPI _____

Primary Care Clinic address _____

Physician's Name _____ Physician's NPI _____

Patient's First Name _____ Last Name _____

Patient's ID _____ Date of Birth _____

Referred to Provider:

Clinic or Hospital Name _____ NPI_____

Clinic or Hospital Address _____

Type of referral (check only one) ☐ MD – Specialist ☐ OP – Outpatient visit ☐ ER – Emergency Room

ICD10 Diagnosis _____ Only Outpatient visit requires ICD-10 procedure code _____

Date of service: From _____ /_____ /_____ to _____ /_____ /_____ Number of visits approved _____

Referral letter comment codes (check no more than 3)

☐ CON ☐ DIA ☐ DXL ☐ HOS ☐ LAB ☐ OUT ☐ REP ☐ STA ☐ THP ☐ XRY

CON	Referral authorized for one consultation **only**	OUT	Outpatient services **only**
DIA	Diagnostic evaluation **only**	REP	Send written report when consultation is completed
DXL	Lab or X-ray services **not authorized**	STA	Send periodic status reports on this patient
HOS	**Do not** Hospitalize without primary care authorization	THP	**No** Therapy services are authorized
LAB	**No Lab** services are authorized	XRY	**No** X-Ray services are authorized

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BCBSMN Referral Number Confirmation _____ Effective Date _____

X12388R11 (03/18)