

Referral Authorization Form Guide

When completing and submitting the Referral Authorization Form:

- The referring physician must be the member’s primary care provider (PCP).
- Please print all information.
- All fields with an asterisk (*) are **required**.
- Incomplete information will result in the referral form being returned to the submitter.
- Each form has its own unique Referral Number. **Do not make copies.**
- Referral forms may be ordered at no charge through [WB Mason](#).

Submission Methods:

- Online at providers.carepartnersct.com
- Email forms to CTHMOSRPRProduct_MedicalClaims_Review@carepartnersct.com
- Mail forms to CarePartners of Connecticut, P.O Box 518, Canton, MA 02021-518
- Fax forms to 617-972-1028

Reminders for specialists/referred to providers:

- Do not exceed the authorized number of visits authorized by the member’s PCP.
- Do not refer to another specialist without consulting with member’s PCP.
- Do not order any diagnostic tests without consent of the member’s PCP.

COMPLETING THE REQUEST FORM

- **Step 1:** Complete the **PCP Information** section with the name and provider ID of the member’s PCP.

PCP INFORMATION	
*Name:	_____ (First) _____ (Last)
Provider ID:	_____
*Date service was requested:	_____
*Date determination was made:	_____
*Preparer:	_____
*PCP signature:	_____

Column	Description
Name	First and last name of the member’s PCP.
Provider ID	CarePartners of Connecticut Provider ID or NPI number.
Date service was requested	Date the PCP would like the member to be seen by the specialist.
Date determination was made	Date the PCP determined the member should be referred to the specialist.
Preparer	Name of person completing the referral authorization form.
PCP Signature	Signature of member’s PCP.

Step 2: Complete the **Patient Information** section.

PATIENT INFORMATION	
*Name:	_____ (First) _____ (Last)
*ID number	_____
*Date of birth:	___ / ___ / _____ Tel: _____
Reason for referral/diagnosis:	_____ _____
Date of appointment (optional):	_____

Column	Description
Name	First and last name of the member
ID number	CarePartners of Connecticut member ID number
Date of birth	Member's date of birth
Tel	Member's telephone number
Reason for referral/diagnosis	Description of the member's condition
Date of appointment	This field is optional

Step 3: Complete the **Consulting Provider Information** section.

CONSULTING PROVIDER INFORMATION	
*Name:	_____ (First) _____ (Last)
Provider ID:	_____
*Address:	_____ _____ _____
Telephone number:	_____
*Setting of care:	<input type="checkbox"/> OFF <input type="checkbox"/> SDC <input type="checkbox"/> OPD <input type="checkbox"/> Other: _____

Column	Description
Name	Name of consulting provider
Provider ID	CarePartners of Connecticut provider ID, NPI, or TIN
Address	Address of consulting provider
Telephone number	Consulting provider's telephone number
Setting of care	OFF: Office SDC: Surgical Day Care OPD: Outpatient Department Other: Please indicate place of service

Step 4: Select an option in the **Requested Service** section to indicate the number of visits authorized.
Note: Be sure to include the number of visits when selecting multiple visits.

*REQUESTED SERVICE
Number of visits authorized.
CHECK ONE BOX ONLY:
<input type="checkbox"/> One visit
<input type="checkbox"/> Multiple visits (#number of visits required): _____

Step 5: Include any special instructions, notes and information from the member’s PCP to the specialist in the **Information From PCP to Accompany Referral** section.

INFORMATION FROM PCP TO ACCOMPANY REFERRAL
Special instructions: _____ _____
Enclosures: _____
TO CONSULTING SPECIALTY PROVIDER
Please return progress notes/consult report to PCP promptly after the patient’s appointment. FURTHER CARE MUST BE AUTHORIZED BEFORE IT IS RENDERED. This referral is for your own professional services only . Please refer patient back to the PCP for any treatment, consultation or diagnostic procedure(s) for which authorization is not specifically stated above. PAYMENT WILL NOT BE MADE FOR SERVICES OR SUPPLIES WHICH HAVE NOT BEEN AUTHORIZED BY PCP. THE MEMBER WILL NOT BE HELD RESPONSIBLE. If you have a question about the authorization, please contact the PCP listed above.

Step 6: Complete the **Provider Group Use Only** section.

PROVIDER GROUP USE ONLY	
Decision: <input type="checkbox"/> Approved <input type="checkbox"/> Denied (Denial letter required) <input type="checkbox"/> Alternative treatment plan _____	
<input type="checkbox"/> Need more information: _____	
Comments: _____	
PCP notified? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	Reviewing physician: _____ Date: _____

Note: Referrals are void if member’s coverage is terminated. Provider staff may confirm CarePartners of Connecticut coverage by calling 888-341-1508. Submit CarePartners of Connecticut claims electronically or mail them to the address stated above. For a copy of our Claims Submission Policy, refer to the Payment Policy section of the [Provider Resource Center](http://carepartnersct.com/providers) at carepartnersct.com/providers.