Referral Authorization Request Form Quick Reference Guide

When completing and submitting the Authorization Request Form:

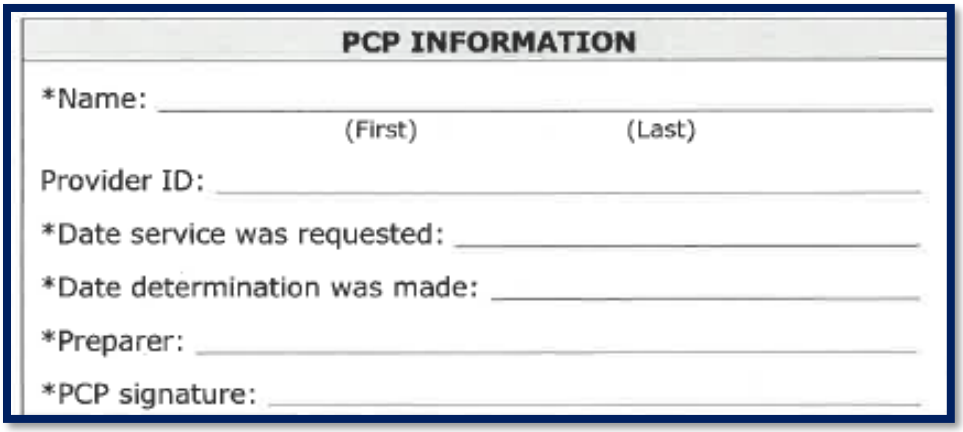
- Please print all information.
- All fields with an asterisk (*) are **required** to be completed.
- Incomplete information will result in the referral form being returned for further information.
- Each form has its own unique Referral Number. **Do not make copies.** (Forms can be requested through WB Mason)
- Email to CTHMOSRPRoduct_MedicalClaims_Review@carepartnersct.com
- Mail to CarePartners of Connecticut P.O Box 9183 Watertown, MA 02471-9183
- Fax to 617.972.1028
- Submit online at providers.carepartnersct.com

Note to Specialists:

- Do not exceed the authorized number of visits.
- Do not refer to another specialist without consulting primary care provider (PCP).
- Please do not or any diagnostic tests without consent of PCP.

Completing the Request Form

Step 1: Complete the PCP Information section.


PCP INFORMATION

*Name: _____
(First) (Last)

Provider ID: _____

*Date service was requested: _____

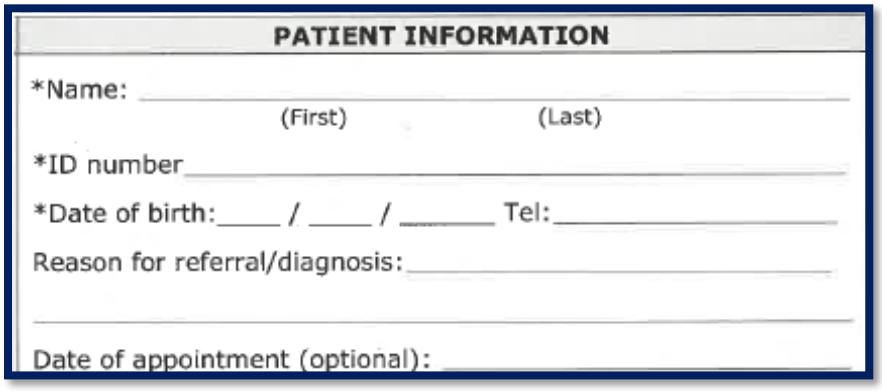
*Date determination was made: _____

*Preparer: _____

*PCP signature: _____

Column	Description
Name	First and last name of the member's PCP or covering physician.
Provider ID	CarePartners of Connecticut Provider ID 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 authorization form
PCP Signature	Signature of member's PCP or covering authorizing the request

Step 2: Complete the Patient Information section.


PATIENT INFORMATION

*Name: _____
(First) (Last)

*ID number _____

*Date of birth: ____ / ____ / _____ Tel: _____

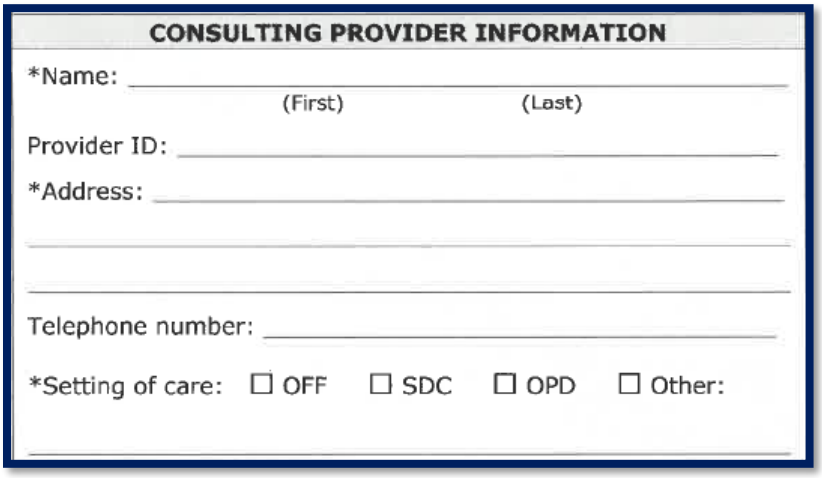
Reason for referral/diagnosis: _____

_____

Date of appointment (optional): _____

Column	Description
Name	First and last name of the patient
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 patients' condition ex. ICD–10 codes
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: ☐ OFF ☐ SDC ☐ OPD ☐ Other:

_____

Column	Description
Name	Name of Consulting provider
Provider ID number	CarePartners of Connecticut Provider ID number
Address	Address of consulting provider
Tel	Provider's telephone number

Column	Description
Setting of care	Off – Office SDC- Surgical Day Care OPD-Outpatient Department, Other – places of service other than OFF, SDC, and OPD.

Step 4: Check one box only for number of visits authorized. Include the number of visits when selecting multiple visits.

***REQUESTED SERVICE**

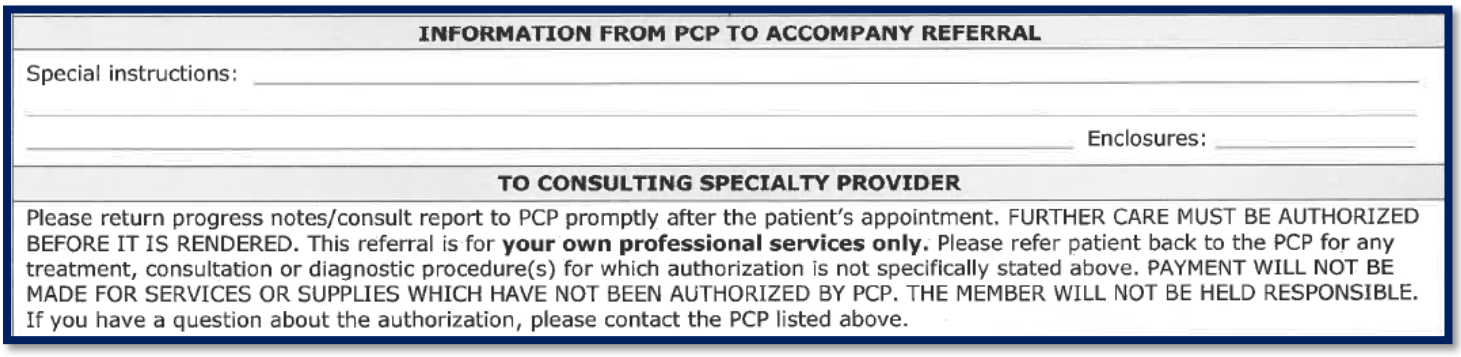
Number of visits authorized.

CHECK ONE BOX ONLY:

☐ One visit

☐ Multiple visits (#number of visits required): _____

Step 5: Please include any special instructions, notes, or information from the members' PCP to the specialist.



INFORMATION FROM PCP TO ACCOMPANY REFERRAL

Special instructions: _____

_____

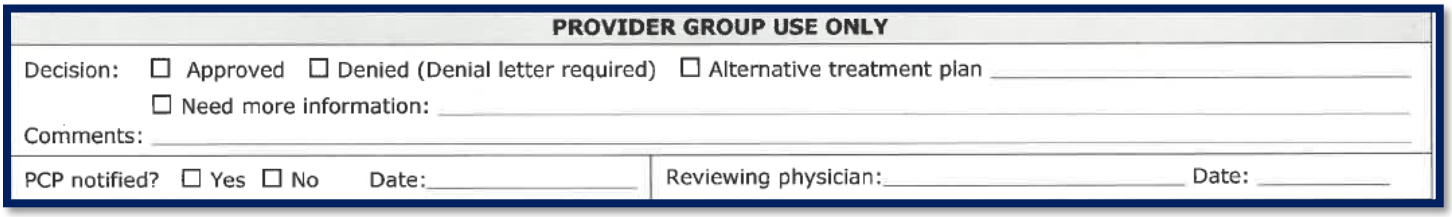
_____ Enclosures: _____

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.

Note: This referral is for your own professional services only. Please refer patient back to 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 the PCP and the member will not be held responsible.

Step 6: For Provider Group Use Only



PROVIDER GROUP USE ONLY

Decision: ☐ Approved ☐ Denied (Denial letter required) ☐ Alternative treatment plan _____

☐ Need more information: _____

Comments: _____

PCP notified? ☐ Yes ☐ No Date:_____ | Reviewing physician:_____ Date: _____

705 Mount Auburn Street, Watertown, MA 02472 www.CarePartnersCT.com

Note: This referral is void if member's coverage is terminated. Your staff may confirm CarePartners of Connecticut coverage by calling Provider Services at 888.341.1508. Please submit CarePartners of Connecticut claims electronically or mail them to the address above. For a copy of our Claims Submission Policy, refer to the Payment Policy section of the Provider Resource Center at carepartnersct.com/providers.