Blue Cross Blue Shield of Michigan

TRUST PREFERRED PROVIDER ORGANIZATION (PPO) PROGRAM REFERRAL FORM

Dear PPO Member:

Your PPO practitioner, facility or laboratory has completed this form because you are being referred for services to a non-PPO practitioner, facility, ancillary provider or laboratory.

Referrals outside the PPO network are required when covered services are medically necessary and not reasonably available within the TRUST network for PPO members. When these conditions are met, **out-of-network** cost sharing (deductibles and copays) are not applied. However, if your contract has **in-network** deductibles, coinsurance or copays, you will still be responsible for those.

Referrals are only valid up to **60 days** after the date of the referral. The referral covers services that are performed within one year of the date of the referral. Retroactive referrals **will not** be approved without documentation in your medical record.

Benefits are not covered when members are referred to non-approved BCBSM facilities — for example, non-approved outpatient mental health.

If you are referred to a practitioner, facility, ancillary provider or laboratory that does not participate in any BCBSM Network (PPO, or Traditional), you may be responsible for paying the provider charges that exceed the BCBSM payment.

TO BE COMPLETED BY REFERRING PRACTITIONER/FACILITY/LABORATORY

Date of Referral	Month	Day	Year	If needed, Date of Revised Referral	Month	Day	Year	Contract Number

Subscriber Name	Patient's Last Name	Patient's First Name	Date of Birth

Non-PPO/Practitioner/Facility/Lab Name	Address	City	State	Zip Code	Telephone

Referring PPO/Practitioner/Facility/Lab Name	Address	City

State	Zip Code	Telephone	**Referring Practitioner or Laboratory** Record digits 3 through 9 of your 10 digit BCBSM PIN	**Referring Facility** Record your 5 digit BCBSM Facility code

Referring Practitioner's License Number	Record all 10 digits of your National Provider Identifier	Record all 10 digits of your National Provider Identifier

Reason For Referral

Anticipated Date of Service/Start Date	Month	Day	Year	Number of Visits	Length of Treatment

All signatures are required for this form to be valid.

Signature of PPO Referring Practitioner/Facility/Laboratory Date

TO BE COMPLETED BY REFERRED PRACTITIONER/FACILITY/ANCILLARY PROVIDER/LABORATORY

Location: ☐ Practitioner's Office ☐ Outpatient Facility ☐ Inpatient Facility ☐ Independent Laboratory

Date of Service/Start Date	Month	Day	Year	End Date	Month	Day	Year	Specific Services Requested

ICD-10 Diagnosis (Code & Description)

All signatures are required for this form to be valid.

Signature of Patient or Authorized Person Date

Signature of NON-PPO Practitoner/Facility/Ancillary Provider/Laboratory Date

If hospitalization is necessary, please inform the referring PPO practitioner immediately and request a new referral.

Referred provider: Return the white copy to the PPO referring practitioner. Give the pink copy to the member. Retain the yellow copy in the patient's record.

If submitting paper claims:

Professional provider: Record the PPO referring practitioner/laboratory seven-digit PIN in field 10D and the 10-digit NPI in field 17b of the CMS-1500 claim. Attach the yellow copy of this form to the claim.

Facility provider: Record the PPO referring practitioner/facility/laboratory PIN in the "Treatment authorization" field and record the 10-digit NPI in field 56 on the UB-04 claim. Attach the yellow copy of this form to the claim.