CONFIDENTIAL— MEDICARE ADVANTAGE

Patient Referral Form

Arizona, Colorado, Florida, Illinois, New York

Bright HealthCare

To ensure proper payment to the referral provider, the primary care physician must fax this completed form to

1-888-337-2174

Requestor's Contact Name:		Requestor's Contact #:	
Patient Information:			
*Name:		*DOB:	
*Member ID #:		*Member Phone #:	
Referring Physician Information:			
*Referring MD Name:		Is this the Member's PCP? ☐ Yes	☐ No
*Phone:	*Fax:	*NPI:	*TIN:
*Address:			
Referral Information:			
*Referral Type: ☐ Initial	☐ Extension to Authorization:		
*Referral Start Date:		Referral End Date:	
*ICD 10 Diagnosis:		Diagnosis Description:	
*Number of Visits:			

This referral covers 99201 – 99205, 99211 – 99215, 99241 – 99245
along with any in office procedures that do not require a prior authorization.

Out of Network Services Require Authorization.

For any service that requires prior auth, please submit a completed Prior Authorization request form.

Visit BrightHealthCare.com for authorization request information related to MA products.

Servicing Provider Information:		
*Referring To (First & Last Name):		*Specialty:
Clinic Name (if applicable):		
*Phone:	*Fax:	*NPI:
*Address:		

INCOMPLETE INFORMATION MAY DELAY THE PROCESS.

Always verify eligibility, benefits, and authorization requirements

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time of services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in the transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient and use, distribute, or coping is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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