Illinois Referral Form

Bright HealthCare

CONFIDENTIAL— **INDIVIDUAL & FAMILY PLAN, SMALL GROUP, or MEDICARE ADVANTAGE**

DATE OF REQUEST: _____ **Fax**: (877) 809-9118

Required Information: To ensure our members receive quality and timely care, please complete this form in its entirety. This form is required for submission and tracking purposes only. Please refer to Bright HealthCare's website to follow separate requirements for services that may require an authorization.

Member Information					
Member ID (9-digit #, begins with 1):					
First Name:		Last Name:			
Date of Birth:		Phone Number:			
Address:					
Diagnosis (ICD -10) Code(s):					
Place of Service (Office only):	POS 11 – Consult and Treat in office setting only				
Date of Service					
Requesting Provider Information (Cannot be a practice)					
NPI #:		Requesting Provider Name:			
Tax ID #:		Street Address:			
Provider Type/Specialty:		City:		State:	Zip:
		Phone:		Fax:	
Servicing Provider Information (Cannot be a practice)					
NPI #:		Servicing Provider Name:			
Tax ID #:		Street Address:			
Provider Type/Specialty:		City:		State:	Zip:
		Phone:		Fax:	

Incomplete documentation of the TIN for the servicing provider and/or facility/practice may require additional information to be requested.

If you have any questions regarding this form and/or would like more information about Bright HealthCare's Utilization Management program, please review our Provider Manual on the Provider Portal, Availity.com. Submission of this form does not guarantee payment for services.

BrightHealthCare.com

Fax—Confidential

To: Bright HealthCare	**Provider Name:**		
To Fax: (877) 809-9118	**Date:**		
Provider		**Provider Fax**	
Re: Referral Request:			
Additional Message:			