Anthem BlueCross BlueShield Medicaid

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TODAY'S DATE: **PROVIDER RETURN FAX #:**

MEMBER INFORMATION (Please verify eligibility prior to rendering service)

NAME (Last Name, First Name): MEMBER ID #: DOB:

ADDRESS: CITY, STATE ZIP:

MEDICAID #: OTHER INSURANCE/WORKER'S COMP:

REFERRING PROVIDER INFORMATION (Check the box where the referral should be faxed)

NAME: OFFICE CONTACT NAME:

MEDICAID PROVIDER #: ANTHEM KENTUCKY MANAGED CARE PLAN, INC. (ANTHEM) #:

GROUP PRACTICE #: NPI #:

PHONE #: FAX #: OTHER PHONE #:

PHONE #: FAX #: OTHER PHONE #:

SPECIALIST CONSULT

CONSULTANT: (Last Name, First Name, Provider Specialty)

ANTHEM PROVIDER #: NPI #: PHONE #: FAX #:

ADDRESS: CITY, STATE ZIP:

ICD-10 CODE/DIAGNOSIS/REASON FOR REFERRAL:

PMH/PREVIOUS STUDIES/TREATMENT:

OF VISITS REQUIRED:

MATERNITY CARE

For initial notification of pregnancy, please use the Maternity Notification Form.
For all other services related to pregnancy, please use this form (e.g., ultrasound, fetal nonstress test).

DIAGNOSTIC STUDY

FACILITY NAME: DOS:

DIAGNOSIS/REASON FOR REFERRAL:

PROCEDURE/CPT CODE:

PMH/PREVIOUS STUDIES/TREATMENTS:

SURGERY REQUEST

SURGEON'S FULL NAME: (Last Name, First Name) DOS: ❑Inpatient ❑ Outpatient ❑ Extended Stay

FACILITY NAME:

DIAGNOSIS/REASON FOR SURGERY:

PROCEDURE/CPT CODE:

PMH/PREVIOUS STUDIES/TREATMENTS:

OTHER-CLINICAL INFORMATION NEEDED

❑DME ❑Home Health ❑Hospice ❑Other

REFERRED TO PROVIDER: (Last Name, First Name) ANTHEM PROVIDER #: NPI #:

DIAGNOSIS/REASON FOR REFERRAL:

PROCEDURE/CPT CODE:

PMH/PREVIOUS STUDIES/TREATMENTS:

PLACE OF SERVICE: ❑ OFFICE ❑ HOME ❑ OUTPATIENT HOSPITAL ❑ INPATIENT HOSPITAL ❑ OTHER

PLEASE ATTACH CLINICAL INFORMATION TO SUPPORT MEDICAL NECESSITY.

This referral is valid only for services authorized by this form. Only completed referrals will be processed. If the consultant/provider recommends another service or surgery, additional authorization is required. Certification does not guarantee that benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions.

To be completed by Anthem: DATE APPROVED:

DATE SPAN: REFERENCE #: INITIALS OF APPROVER:

To confirm precertification is required for this service, use the Precertification Lookup tool on the provider self-service website at **www.anthem.com**.

Important Note: You are not permitted to use or disclose Protected Health Information about individuals who you are not currently treating or have enrolled to your practice. This applies to Protected Health Information accessible in any online tool or sent in any medium, including mail, email, fax or other electronic transmission.

www.Anthem.com/KYMedicaiddoc

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