**I/T/U HEALTH REFERRAL FORM**

This form is only needed for services received outside of an Indian Health Clinic (IHC) and is intended to protect tribal members from potential cost-sharing.

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| Date of Referral\*: | Date of Service for Referred Services\*: |  |
| Patient Name\*: (First and Last Name) |
| Patient Insurance ID#: | Date of Birth\*: |
| IHC Referring\*:  | NPI#: |
| IHC Referring Provider Address\*: |
| IHC Telephone Number\*: | IHC Fax Number: |
| Referral Provider Facility/Specialty\*: (Referred to) | Referral Provider NPI# |
| Referral Provider Address\*: |
| ICD-10 Diagnosis Code(s): | Description\*: |
| Service/Treatment Request\*: |

Initial Consult: Office Visit: 1) 2) 3) (Other)

Procedure(s) – CPT codes:

Description of Procedure(s) and Duration of Treatment:

Inpatient Stay: (Hospital, SNF, etc.): Outpatient Stay:

Length of Stay (L0S): 1) 2) 3) (OTHER)

Duration requesting visits (i.e.: 2x/wk x2 wks)

PT OT ST

Type of Therapy

This patient is a member of a federally recognized Indian Tribe and enrolled in a Qualified Health Plan (QHP) with comprehensive cost-sharing protections under 45 C.F.R. § 156.410(b)(2) or (3) (“zero cost-sharing variation” or “limited cost-sharing variation”), and 45 C.F.R. § 156.420(b)(1) and (2), which specify that a QHP issuer may not impose any cost-sharing on an Indian for Essential Health Benefits furnished through Purchased and Referred Care Program (formerly known as Contract Health Services).

With a qualified referral, Carrier will reimburse the provider for the full allowed amount of the encounter; neither the Tribe nor the patient is responsible for any copay, coinsurance, or deductible when the services are performed by an In-Network Provider. Please identify referring physician on all claims.

**A referral or prior authorization may be required by Carrier before receiving items or services.**

**Please note that this is not an authorization for payment.**

**\* Required information**

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