PrimeCare health group

BCBSND Patient Referral Form

Please fill in each section

Patient Name:	**Benefit Plan #:**	**Date of Birth:**

Patient Address:	**City:**	**State:**	**Zip:**

Dates of Service:

Beginning Date: _____

Ending Date: _____

- Referral beginning date can be backdated up to one year prior to today's date.
- Referral ending date can be up to two years in the future from today's date.

Diagnosis:
Please list ICD-10 Code

Attending Provider:

Facility Name:

Facility Address:	**City:**	**State:**	**Zip:**

Referred To Name:

Referred To Address:	**City:**	**State:**	**Zip:**

Completed by:	**Telephone Number:**	**Fax Number:**

Determination: Denied Approved

Network Medical Director Signature: _____ **Date:** _____

INCOMPLETE REFERRALS WILL BE RETURNED TO THE ATTENDING PROVIDER

PLEASE FAX COMPLETED FORM TO: OUT OF NETWORK REFERRALS 701.712.4098