

Retrospective Administrative Referral

Attn: Provider Services Phone: (877) 823-4529 Fax: (405) 530-3228 Number of Pages: _____

Prospective Administrative Referral

Attn: Care Management Phone: (877) 252-6002 Fax: (405) 530-3217 Number of Pages: _____

SOONERCARE REFERRAL REQUEST

Please complete the information below to document your attempts to obtain a referral from the PCP/CM. **Fax this completed form to SoonerCare.** Your referral request will be considered and you will receive written notice of approval or denial. Include any necessary medical records. **ALL PAYMENTS FOR SERVICES ARE SUBJECT TO COVERAGE LIMITATIONS UNDER THE CURRENT OKLAHOMA MEDICAID PROGRAM.**

RENDERING PROVIDER'S NAME:

Provider #

Contact Person:

Address:

Telephone and Extension:

Fax:

PATIENT INFORMATION:

Completed by: Provider Provider Rep Care Management

Patient Name:

Phone: ()

RID:

Type of service:

- Office Visit
- Surgery
- Durable Medical Equipment
- Other: _____

Diagnosis codes:

- 1. _____
- 2. _____
- 3. _____

Date(s) of service:

- 1. _____
- 2. _____
- 3. _____

Notes/Other Information:

PCP/CM CONTACT INFORMATION:

PCP/CM Name:

Telephone: ()

CONTACTS:

Date: _____ Result of Contact: _____

Date: _____ Result of Contact: _____

****FOR OHCA USE ONLY****

MEDICAL ADMINISTRATIVE

Approved by:

PCP/CM #

Reason:

Referral #