



U.P. Blue Out-of-State Referral Preauthorization Form



A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

Dear Provider:

This form must be completed in addition to the standard BCBSM PPO Referral form (CN 9147 AUG 05) when requesting approval to refer U.P. Blue members to out-of-state providers.

**Fax both the standard PPO Referral form and this form to
Upper Peninsula Health Plan at (906) 225-7720**

Please fill out completely

Patient Information

Patient Name (First and Last)	BCBSM Contract Number	BCBSM Group Number
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Referring Physician Information

Referring Physician Name	Specialty	Phone Number	Fax Number
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Out-of-State Physician/Laboratory/Facility Information

Out-of-State Provider Name	Specialty	Phone Number	Fax Number
Address	City	State	Zip Code

Reason for Referral

What services are being requested?

Why are you referring out-of-state?

No PPO In-State Provider Available PPO In-State Provider unable to schedule in timely manner

Other _____

Referring Physician Signature: _____ **Date:** _____

Upper Peninsula Health Plan Use Only

Determination

- Able to waive out-of-network cost sharing requirements
- Unable to waive out-of-network cost sharing requirements

Signature: _____

Date: _____