



**USABLE ADMINISTRATORS
PRIMARY CARE NETWORK (PCN)
REFERRAL AUTHORIZATION FORM**

**IF YOU ARE REFERRING THE MEMBER TO AN OUT-OF-NETWORK PROVIDER,
please fax a copy of this form to USABLE Administrators at 501.378.2965**

Member Name: _____ **ID#** _____

Specialist: _____

Diagnosis(es): _____

Reason for Referral: _____

Restrictions: _____

Other: _____

Date Span: _____ **to** _____ **Number of visits** _____

PCP Name: _____

(Print Name)

(Signature)

(Date)

ABCBS/USABLE 5-digit Provider #:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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(Specialists should indicate this # in field #23 on the HCFA claim form)

⇒ Referral services are subject to member eligibility and the benefits available through the member's plan; therefore, this referral should not be considered a guarantee of payment.

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IMPORTANT INFORMATION FOR THE PHYSICIAN AND MEMBER**

PRIMARY CARE PHYSICIAN:

- **Out-of-Network referrals require prior notification. Please fax a copy of the referral authorization form to USable Administrators at 501.378.2965. Services referred to or provided by an OON provider may not be eligible for reimbursement or may be covered at a reduced benefit level.**

SPECIALIST:

- Please contact the PCP if additional referrals are recommended.
- X-ray and lab results may be available. To avoid duplication, please check with the Primary Care Physician.

If more information about this process is needed, you may contact the customer service phone number on the member's ID card or a local Arkansas Blue Cross and Blue Shield Regional Office.

To verify eligibility and benefits, please call the Customer Service telephone number on the member's ID card. Please have the member's card ready when you call.