

Referral Form

Mail Yellow copy of completed form to:
Keystone Mercy Health Plan
Claims Processing Department
P.O. Box 7115
London, KY 40742

KEYSTONE MERCY
 A Program of Keystone First and Mercy Health Plan



Referral # _____

| | | |
|---------------------------|--------------------|------------------------|
| Member's Name | Member's ID Number | Member's Date of Birth |
| Requesting PCP Group Name | | PCP Group ID Number |

Assigned Laboratory, as indicated on Member's ID Card (required for submission). Please check appropriate box.

Quest
 CHOP Lab
 University of Penn Lab
 Mercy Lab
 District Health Center

Keystone Mercy Health Plan members and providers please note:

- Referrals are valid for 180 days from date of Referral Request. Date of Service must not be prior to date of Referral Request.
- This referral form may only be used for referral from a PCP to a participating Specialist. All referrals to non-participating providers require prior authorization.
- Referral by the PCP does not guarantee payment.
- Payment is based on the member's eligibility at the time of service and medical necessity for services performed.
- Keystone Mercy will only pay for services specifically noted and requested by the PCP and covered under the benefit plan.
- Services rendered without a referral will not be covered by Keystone Mercy Health Plan.
- Specialists cannot refer to other Specialists. Additional specialty services must be coordinated by the PCP.
- Please refer to the Provider Manual for information on services that do not require a referral.

This member is being referred to:

The following information is required. Please use group or facility name/ID unless provider is a sole practitioner.

| | | |
|----------------|----------------|--------------------|
| Provider Name | Specialty Type | Provider ID Number |
| Street Address | City | Zip Code |

Diagnosis and ICD-9 Code (Please provide all available diagnoses.)

PCP must check ONE of the following:

- Referral for CONSULTATION, DIAGNOSTIC STUDIES and TREATMENT
Good for unlimited visits within 6 months (180 days).
- Referral for CONSULTATION, DIAGNOSTIC STUDIES and TREATMENT
 Number of visits approved (circle one): 1 visit 2 visits 3 visits 4 visits 5 visits Other _____
- Therapy Services (Physical, Speech, Occupational). Initial evaluation visit requires a referral.
 Physical, Speech and Occupational Therapy exceeding 24 visits in a calendar year requires Prior Authorization.

Comments

| | | |
|-----------------------|-----------------|-----------------------|
| Authorizing Signature | Contact Phone # | Referral Request Date |
|-----------------------|-----------------|-----------------------|

If you have any questions, please call Provider Services at 1-800-521-6007.

Referral submission and inquiry can also be accessed through NaviNet®.
Go to: <https://connect.navinet.net>

10.2088 KM