In-Network Referral Form

FOR FAX USE ONLY

FAX Number: 1-888-553-0075

BlueCross BlueShield of Western New York

1. _____ _____
   Referred by (PCP Name) Provider ID # or NPI # (and address, if more than one office)

   _____ _____
   PCP Office Contact Name Contact Phone Number

2. _____ _____
   Member Name Nine-digit ID # (no prefix)

3. _____ _____
   Referred to (Specialist Name)* Provider ID # or NPI # (and address if more than one office)

4. _____
   Diagnosis Code

5. Check one:

   ☐ Consultation Only

   ☐ Consultation and Diagnostic Testing

   ☐ Consultation and Treatment

6. Start Date: _____ End Date: _____

7. # of Months (1 to 6): _____

8. # of Visits: _____

9.

Referral #								

Referral letter will be sent to the member within 7 to 10 days.

*** PT, OT, ST, and Podiatry have pre-assigned treatment options.**