ROPER ST. FRANCIS

Roper St. Francis Teammate Health Plan

REQUEST FOR NON-NETWORK SERVICES

THIS FORM MUST BE COMPLETED BY THE REFERRING PHYSICIAN AND MUST BE ACCOMPANIED BY MEDICAL RECORDS THAT SUPPORT THE MEDICAL NECESSITY OF THIS REQUEST. FAILURE TO SUBMIT SUPPORTING MEDICAL RECORDS MAY BE MORE LIKELY TO RESULT IN A DENIAL.

PATIENT INFORMATION

Patient's Name:_____ ID#_____

Patient's DOB: _____ Employee's Name: _____

REFERRING IN-NETWORK PROVIDER INFORMATION

Provider Name: _____ Tax ID _____

Phone: _____ FAX _____

NON-NETWORK PROVIDER INFORMATION

Facility _____ City_____St _____ Phone _____

Physician_____Specialty_____City_____St_____Phone _____

Other _____ City_____St _____ Phone _____

ICD-9/10 DX Code(s)_____Dates of Service (if known) _____

CPT/HCPSC Codes to be performed _____

Reason service(s) cannot be provided within the Roper St. Francis Healthcare provider network:

_____

_____

_____

REFERRING PHYSICIAN'S SIGNATURE _____

Approval of a NON-NETWORK is not the same, nor will be substituted, for a Pre-Certification for which the plan requires.

Completed forms should be sent to RSFInquiries@bcbssc.com

Approved _____ Date _____