CarePartners
of Connecticut
MEDICARE ADVANTAGE

Referral Authorization Form Guide

When completing and submitting the Referral Authorization Form:
- The referring physician must be the member's primary care provider (PCP).
- Please print all information.
- All fields with an asterisk (*) are **required**.
- Incomplete information will result in the referral form being returned to the submitter.
- Each form has its own unique Referral Number. **Do not make copies.**
- Referral forms may be ordered at no charge through WB Mason.

Submission Methods:
- Online at providers.carepartnersct.com
- Email forms to CTHMOSRPRoduct_MedicalClaims_Review@carepartnersct.com
- Mail forms to CarePartners of Connecticut, P.O Box 518, Canton, MA 02021-518
- Fax forms to 617-972-1028

Reminders for specialists/referred to providers:
- Do not exceed the authorized number of visits authorized by the member's PCP.
- Do not refer to another specialist without consulting with member's PCP.
- Do not order any diagnostic tests without consent of the member's PCP.

COMPLETING THE REQUEST FORM

- **Step 1:** Complete the **PCP Information** section with the name and provider ID of the member's PCP.

PCP INFORMATION

*Name: ______________________________
(First) (Last)

Provider ID: ______________________________

*Date service was requested: ______________________________

*Date determination was made: ______________________________

*Preparer: ______________________________

*PCP signature: ______________________________

PCP Information	Description
Name	First and last name of the member's PCP.
Provider ID	CarePartners of Connecticut Provider ID or NPI number.
Date service was requested	Date the PCP would like the member to be seen by the specialist.
Date determination was made	Date the PCP determined the member should be referred to the specialist.
Preparer	Name of person completing the referral authorization form.
PCP Signature	Signature of member's PCP.

Step 2: Complete the **Patient Information** section.

PATIENT INFORMATION

*Name: ____________________
(First) (Last)

*ID number ____________________

*Date of birth: ____ / ____ / ____ Tel: ____________________

Reason for referral/diagnosis: ____________________

____

Date of appointment (optional): ____________________

Patient Information	Description
Name	First and last name of the member
ID number	CarePartners of Connecticut member ID number
Date of birth	Member's date of birth
Tel	Member's telephone number
Reason for referral/diagnosis	Description of the member's condition
Date of appointment	This field is optional

Step 3: Complete the **Consulting Provider Information** section.

CONSULTING PROVIDER INFORMATION

*Name: ____________________
(First) (Last)

Provider ID: ____________________

*Address: ____________________

____

____

Telephone number: ____________________

*Setting of care: ☐ OFF ☐ SDC ☐ OPD ☐ Other:

Consulting Provider Information	Description
Name	Name of consulting provider
Provider ID	CarePartners of Connecticut provider ID, NPI, or TIN
Address	Address of consulting provider
Telephone number	Consulting provider's telephone number
Setting of care	OFF: Office SDC: Surgical Day Care OPD: Outpatient Department Other: Please indicate place of service

Step 4: Select an option in the **Requested Service** section to indicate the number of visits authorized.
Note: Be sure to include the number of visits when selecting multiple visits.

***REQUESTED SERVICE**

Number of visits authorized.

CHECK ONE BOX ONLY:

☐ One visit

☐ Multiple visits (#number of visits required): ______________

Step 5: Include any special instructions, notes and information from the member's PCP to the specialist in the **Information From PCP to Accompany Referral** section.

INFORMATION FROM PCP TO ACCOMPANY REFERRAL

Special instructions: ____

____ Enclosures: ______________

TO CONSULTING SPECIALTY PROVIDER

Please return progress notes/consult report to PCP promptly after the patient's appointment. FURTHER CARE MUST BE AUTHORIZED BEFORE IT IS RENDERED. This referral is for **your own professional services only.** Please refer patient back to the PCP for any treatment, consultation or diagnostic procedure(s) for which authorization is not specifically stated above. PAYMENT WILL NOT BE MADE FOR SERVICES OR SUPPLIES WHICH HAVE NOT BEEN AUTHORIZED BY PCP. THE MEMBER WILL NOT BE HELD RESPONSIBLE. If you have a question about the authorization, please contact the PCP listed above.

Step 6: Complete the **Provider Group Use Only** section.

PROVIDER GROUP USE ONLY

Decision: ☐ Approved ☐ Denied (Denial letter required) ☐ Alternative treatment plan ______________

☐ Need more information: ______________

Comments: ______________

PCP notified? ☐ Yes ☐ No Date:______________ | Reviewing physician:______________ Date: ______________

Note: Referrals are void if member's coverage is terminated. Member eligibility and benefit specifics may be verified by logging on to the secure Provider portal or by contacting CarePartners of Connecticut Provider Services at 888-341-1508.

Providers may check the status of an existing referral by using the Referral Status Inquiry on the secure Provider portal. The referral status inquiry tool provides the status of any referral submitted to CarePartners of Connecticut, regardless of how the referral was initially submitted.

For additional information about referrals, view to the Referral, Prior Authorization and Notification Policy available in the Provider Resource Center at carepartnersct.com/providers.