ParkCare Plus HEALTH PLAN

IMS INSURANCE MANAGEMENT SERVICES

Out of Network Referral Form

Date of Request: _____

Referring Provider Information:

Physician Name _____ Signature _____

Phone _____ Fax _____

Tax ID _____

Referral Created By _____ Phone _____

Patient Information:

Last Name _____ First Name _____ MI _____

ParkCare Plus ID # _____ DOB _____ Gender ◯ MALE ◯ FEMALE

Reason for Referral: (*UC Health facilities/physicians are the out of network Preferred Providers)

Name of Provider being Referred to _____

Address _____ **City** _____ **ST** _____ **ZIP** _____

Phone _____ **Fax** _____

Tax ID _____ **Office Contact** _____

Reason an In-Network Provider Cannot be Utilized:

ICD 10 /Diagnosis Description _____

Service/Specialty Requested _____ **Procedure Codes** _____

Anticipated Date of Service _____ **End of Treatment Date** _____

Type of Service Requested: ◯ Consultation ◯ Radiology Services ◯ Lab Services ◯ Surgery

◯ **Other** _____

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Continuation of Care: (excludes REQUESTS for Primary Care Providers)

Attach PDF files

Please attach a copy of the last 2 office visit progress notes for substantiation

If files are too large, please Fax or Email **Fax: (806)373-0995** **Email: PMC-Referral@imsm.net**

Notice:

Referrals should be submitted before services are rendered. The referral is not a guarantee of benefits or eligibility. For Maximum plan benefits all services (lab, x-ray, surgery, etc.) must be performed in network if possible. All services performed elsewhere are subject to reduced benefits unless approved. For questions regarding CoPays or Health Plan eligibility, please contact IMS toll-free at 1-800-687-5944.

Approval of the referral does not guarantee a visit with the referred physician; it is the patient's responsibility to contact the provider's office to ensure the provider is available to accept them as a patient and provide any additional information the provider may need.

This referral is **not** a medical necessity determination. For PreCertification in accordance with the plan requirements, please contact Insurance Management Services

☐ I hereby agree, that I have read and acknowledge all the notices of this form.

Form Submission:

Submit Form to IMS

Confidentiality Notice:

This information is intended only for the use of the individual or entity to which it is addressed, and contains information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this message in error, please notify us immediately by telephone and return the original message to the above address.