THE HSC HEALTH CARE SYSTEM
Health Services for Children with Special Needs, Inc.

HSCSN Out of Network Services Referral Form

This form must be completed by a treating practitioner. Fax this form and supporting documents to HSCSN Utilization Management at **Fax: 202-721-7190** or email: **UM@hschealth.org**. **IMPORTANT TO NOTE: This request will not be processed unless all of the items below are completed.**

DATE OF REFERRAL:	
REFER-FROM PROVIDER	**ENROLLEE**
Refer-From Provider (MD or NP):	**Enrollee Name:**
Provider NPI #:	**Enrollee ID:** **DOB:** **Enrollee Age:**
Provider Phone #: **Fax #:** **Provider Email:**	**Parent/Guardian Name:** **Relationship to Enrollee:**
Refer-From Provider Signature:	

REASONS FOR REFERRAL

Reason for referral (including all relevant clinical information): Click to enter text.

Check all that apply:

☐ **Out of State Provider** ☐ **No Network Providers Available** ☐ **Specialized Services**

SPECIALTY TYPE (Select Only One Referral per Form)

	Allergy	**Other (specify)**	
	Cardiology	**Neurosurgery**	
	Cardiovascular Surgery	**Nuclear Medicine**	
	Dermatology	**Urology**	
	Endocrinology	**Occupational Therapy**	
	Gastroenterology	**Orthopedic Surgery**	
	General Surgery	**Otolaryngology**	
	Genetics	**Physical Medicine & Rehab**	
	Gynecology	**Physical Therapy**	
	Hematology and Oncology	**Plastic Surgery**	
	Infectious Disease	**Psychiatry**	
	Behavior Health Service (Specify Type)	**Pulmonary**	
	Nephrology	**Radiology**	
	Neurology	**Rheumatology**	
	Ophthalmology	**Speech Therapy**	
	Optometry	**Immunology**	

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REFER-TO PROVIDER - CONTACT INFORMATION
Refer-To Provider Name:
Refer-To Provider Credentials:
Refer To Facility/Practice Name:
Address:
Office Point of Contact Name:
Office Phone:
Office Fax:
Office Point of Contact E-mail:
Refer-To Provider NPI#:

Authorization is not a guarantee of payment.
Payment of benefits is subject to a member's eligibility on the date that the service is rendered and any other contractual provisions of the plan/carrier.
12.06.19 RH

For more information visit www.hscsnhealthplan.org.
For reasonable accommodations please call (202) 467-2737.

If you do not speak and/or read English, please call 202-467-2737 between 7:00 a.m. and 5:30 p.m. A representative will assist you. **English.**

Si no habla o lee inglés, llame al 202-467-2737 entre las 7:00 a.m. y las 5:30 p.m. Un representante se complacerá en asistirle. **Spanish.**

የእንግሊዝኛ ቋንቋ መናገርና ማንበብ የማይችሉ ከሆነ ከጧቱ 7:00 ሰዓት እስከ ቀኑ 5:30 ባለው ጊዜ በስልክ ቁጥር 202-467-2737 በመደወል እርዳታ ማግኘት ይችላሉ። **Amharic.**

Nếu bạn không nói và/hoặc đọc tiếng Anh, xin gọi 202-467-2737 từ 7 giờ 00 sáng đến 5 giờ 30 chiều. Sẽ có người đại diện giúp bạn. **Vietnamese.**

如果您不能講和/或不能閱讀英語，請在上午 7:00 到下午 5:30 之間給 (202) 467-2737 打電話，我們會有代表幫助您。**Tradi ional Chinese.**

영어로 대화를 못하시거나 영어를 읽지 못하시는 경우, 오전 7시 00분에서 오후 5시 30분 사이에 (202) 467-2737번으로 전화해 주시기 바랍니다. 담당 직원이 도와드립니다. **Korean.**

Si vous ne parlez pas ou lisez l'anglais, s'il vous plaît appeller 202-467-2737 entre 7:00 du matin et 5:30 du soir. Un représentant vous aidera. **French.**

DHCF Department of Health Care Finance
WE ARE WASHINGTON DC
GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

This program is funded in part by the Government of the District of Columbia Department of Health Care Finance.

HSCSN complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.