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:
Provider Phone #:	Enrollee Age:
Provider Fax #:	Parent/Guardian Name:
Provider Email:	Relationship to Enrollee:

Refer-From Provider Signature:

REASONS FOR REFERRAL

Reason for referral (including all relevant clinical information):

Additional Records Attached: ☐

Check all that apply:

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

DESCRIPTION OF SERVICES TO BE PROVIDED: (can be a description from proposed providers)

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

Signature of Ordering Provider: _____ Date: _____

Printed Name: