

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.

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:	<u> </u>
REASONS FOR REFERRAL	
Reason for referral (including all relevant clinical informati	ion):
Reason for referral (including all relevant clinical information of the second	ion):
	ion):
Additional Records Attached: □ Check all that apply:	work Providers Available □ Specialized Services
Additional Records Attached: □ Check all that apply: □ Out of State Provider □ No Netv	



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:	