



Missouri Care[™]

H E A L T H P L A N

SPECIALTY REFERRAL FORM

Prior Authorization Department
Phone: (800) 322-6027 Option #2, then press (3)
Fax: (866) 946-2052

Specialty Referral Form is for use by contracted providers and is for evaluation only

Member Name: _____
I.D.# _____ DOB: _____
PCP/Specialist/Referring Provider: _____
Phone # : (_____) _____
Office Contact Name: _____ PCP FAX#: (_____) _____
Referred To: _____ Specialty: _____
Facility: _____ Fax: (_____) _____

SERVICE REQUESTED:

- _____ ENT if over 21 (3 visits)
- _____ Allergist if over 21 (3 visits)
- _____ Pain Management (3 visits)
- _____ Plastic Surgery (3 visits)
- _____ Cardiac Rehab (3 visits)
- _____ Diabetic Self Management Training* (3 visits)
- _____ Podiatry (3 visits)

* Children <21y/o & pregnant women only

PT/OT/ST referrals must be submitted on the Therapy Referral Form

DIAGNOSIS: _____ **ICD-9:** _____

Document additional clinical if necessary:

Procedures that require prior authorization must be called or faxed into the Prior Authorization Department. Missouri Care is unable to back-date requests. Authorization must be obtained prior to rendering service.

Authorization Number: _____

Start Date: _____ **End Date:** _____ **Number of visits approved:** _____

Specialty Referral Form will be faxed to requesting provider with assigned authorization number following approval. The requesting provider is responsible to notify specialist or PCP of authorization number.