



**REFERRAL FORM
UTILIZATION MANAGEMENT**

Patient Information:

First Name: _____ Last Name: _____
ID Number: _____ Date of Birth: _____

Referral Information:

Referred to: _____ Phone Number: _____
Address: _____ Fax Number: _____
_____ Tax ID Number: _____

Diagnosis/Suspected Condition(s):

ICD9 code(s): _____
Description: _____
Procedure Code(s): _____
Description: _____

Referral for (check one):

- Specialty Services
- Second Opinion
- Other: _____

Referring Physician (please print): _____
Signature: _____ Date: _____

Please Fax referral request to RCI at (308) 635-2018 for approval/benefits.

IMPORTANT NOTICE: For maximum plan benefits all services (lab, x-ray, surgery, etc.) must be performed in-network if possible. All services done elsewhere are subject to reduced benefits unless approved.

RCI ONLY:
Service(s):
 Can be done In-Network
 Cannot be done In-Network
Payment:
 In-network
 Non-network
Authorization Signature: _____

CONFIDENTIALITY NOTICE

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Regional Care, Inc.
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