



**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 Please specify: \_\_\_\_\_
- Second Opinion
- Other: \_\_\_\_\_

Referring Physician (please print): \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Referring Physician Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

**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: \_\_\_\_\_

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Regional Care, Inc.  
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