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: Click here to enter a date.	
REFER-FROM PROVIDER	**ENROLLEE**
Refer-From Provider (MD or NP): Click to enter text.	**Enrollee Name:** Click to enter text.
Provider NPI #: Click to enter text.	**Enrollee ID:** Click to enter text. **DOB:** Click to enter text. **Enrollee Age:** Click to enter text.
Provider Phone #: Click to enter text. **Fax #:** Click to enter text. **Provider Email:** Click to enter text.	**Parent/Guardian Name:** Click to enter text. **Relationship to Enrollee:** Click to enter text.
Refer-From Provider Signature:	

REASONS FOR REFERRAL

Reason for referral (including all relevant clinical information): Click to enter text.

Check all that apply:

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

SPECIALTY TYPE (Select Only One Referral per Form)

	Allergy	**Other (specify)**	
	Cardiology	**Neurosurgery**	
	Cardiovascular Surgery	**Nuclear Medicine**	
	Dermatology	**Urology**	
	Endocrinology	**Occupational Therapy**	
	Gastroenterology	**Orthopedic Surgery**	
	General Surgery	**Otolaryngology**	
	Genetics	**Physical Medicine & Rehab**	
	Gynecology	**Physical Therapy**	
	Hematology and Oncology	**Plastic Surgery**	
	Infectious Disease	**Psychiatry**	
	Behavior Health Service (Specify Type)	**Pulmonary**	
	Nephrology	**Radiology**	
	Neurology	**Rheumatology**	
	Ophthalmology	**Speech Therapy**	
	Optometry	**Immunology**	

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REFER-TO PROVIDER - CONTACT INFORMATION
Refer-To Provider Name: Click to enter text.
Refer-To Provider Credentials: Click to enter text.
Refer To Facility/Practice Name: Click to enter text.
Address: Click to enter text.
Office Point of Contact Name: Click to enter text.
Office Phone: Click to enter text.
Office Fax: Click to enter text.
Office Point of Contact E-mail: Click to enter text.
Refer-To Provider NPI#: Click to enter text.

Authorization is not a guarantee of payment.
Payment of benefits is subject to a member's eligibility on the date that the service is rendered and any other contractual provisions of the plan/carrier.
12.06.19 RH

For more information visit hscsnhealthplan.org.
For reasonable accommodations please call (202) 467-2737.

If you do not speak and/or read English, please call 202-467-2737 between 7:00 a.m. and 5:30 p.m. A representative will assist you. **English.**

Si no habla o lee inglés, llame al 202-467-2737 entre las 7:00 a.m. y las 5:30 p.m. Un representante se complacerá en asistirle. **Spanish.**

የእንግሊዝኛ ቋንቋ መናገርና ማንበብ የማይችሉ ከሆነ ከጧቱ 7:00 ሰዓት እስከ ቀኑ 5:30 ባለው ጊዜ በስልክ ቁጥር 202-467-2737 በመደወል እርዳታ ማግኘት ይችላሉ። **Amharic.**

Nếu bạn không nói và/hoặc đọc tiếng Anh, xin gọi 202-467-2737 từ 7 giờ 00 sáng đến 5 giờ 30 chiều. Sẽ có người đại diện giúp bạn. **Vietnamese.**

如果您不能講和/或不能閱讀英語，請在上午 7:00 到下午 5:30 之間給 202-467-2737打電話，我們會有代表幫助您。**Chinese.**

영어로 대화를 못하시거나 영어를 읽지 못하시는 경우, 오전 0시 00분에서 오후 0시 00분 사이에 202-467-2737번으로 전화해 주시기 바랍니다. 담당 직원이 도와드립니다. **Korean.**

Si vous ne parlez pas ou lisez l'anglais, s'il vous plaît appeller 202-467-2737 entre 7:00 du matin et 5:30 du soir. Un représentant vous aidera. **French.**

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