



Baptist Health Quality Network Referral Authorization

**A REFERRAL MUST BE OBTAINED BEFORE
SPECIALIST SERVICES ARE RECEIVED.**

There is no coverage for Specialist Care without a PCP Referral.

No coverage is provided for any care outside of the BHQN.

* Date Written:	
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Patient Information:			
* Patient Name:		* Date of Birth:	
* Employee Name:		* Employee Member ID or SSN:	

Referred to:			
* Provider / Facility Name:		Address:	
* Tax Identification Number:		City:	Zip:

Referral Information:			
Patient Diagnosis / ICD10:		Dates of Service:	to

Referred by:			
* Provider Name (Last, First):		Address:	
Contact:		Phone:	City:

*** Required Fields**

Please send form to: **UMR**
Attention: **DE Referral**
Fax Number: **(877) 293-4926**
E-Mail: BHSFL2016@umr.com

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