BlueCross BlueShield of Oklahoma

BlueLincs HMO Referral/Authorization Request Form

For your convenience, preauthorization requests can also be submitted via iEXCHANGE, a Web-based automated tool. To learn more, visit Getting Started with iEXCHANGE.

Authorization Request		**Referral Request**	

☐ MRI ☐ ER Visit ☐ DME ☐ Out of Network ☐ Outpatient Surgery ☐ Obstetric ☐ Inpatient Admission ☐ Other ☐ Concurrent

Mail to the Following Address or Fax to:	
BlueLincs Preauthorization PO Box 655924 Dallas, TX 75265-5924	Fax: (918) 549-2358

Member/Patient Data:			
Subscriber ID:		**Group #**	
Subscriber Name			
Patient Name		**Date of Birth**	
Date of Service (if known)			

Provider Data:							
PCP Name					**Rendering NPI**		
Specialist Name					**Rendering NPI**		
Address of Requestor							
Date of Service (if known)							
Procedure Codes: (primary first)							
Diagnosis Codes: (primary first)							
Place of Treatment	Please check one of the boxes: ☐ Provider Office ☐ Outpatient Facility ☐ Inpatient Facility ☐ Other						
Contact Person			**Phone**		**Fax**		

Please attach supporting documentation: history & physical, letter of medical necessity, original photographs, etc. For additional requirements, please visit the **medical policy** page of our provider website.

Payment depends upon member eligibility, benefits and participation in the BlueLincs Program.

All necessary information is required before your request can be completed.