PREMERA HMO

CLEAR FORM

Referral Request Form

For Primary Care Provider Referral Request for HMO members

Submit requests to:
Fax: 888-704-2091

1. Member Information & Background

Date of referral request: _____

Patient's name: _____

Date of birth: _____

Patient ID #: _____

Primary care provider name: _____

Contact name: _____

Contact phone #: _____ Fax #: _____

☐ New referral

☐ Update of existing referral*

*Referral #: _____

*Update details:

2. Request Information

☐ Office visit

Specialist provider name: _____

Provider specialty: _____

Specialty provider address: _____

_____

Number of visits requested: _____

Date span requested:

_____ - _____

ICD-10 codes: _____