



## 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	
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### Referred by:

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

**\* Required Fields**

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

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