REFERRAL FORM – ALTERNATIVE THERAPIES FOR CHRONIC PAIN MANAGEMENT

Note: This benefit is available only to members 21 years of age or older.
Please complete this form and fax to **1-866-946-2052**.

Date: ______________

PATIENT INFORMATION	
Member Name (Last, First, MI):	**Member DOB:**
Member Address (Full Address):	
Subscriber ID#:	

REFERRING PROVIDER INFORMATION	
Name of Referring MD or DO:	
Requesting Provider NPI#:	**Referring Provider Tax ID:**
Office Address:	
Phone Number:	**Fax Number:**
Contact Name for Questions about the Referral:	

REASON FOR REFERRAL – please check the box next to qualifying pain category
□ Chronic non-cancer neck and/or back pain
□ Chronic pain post traumatic injury
□ Other chronic pain diagnosis

DIAGNOSIS – required to be qualifying code as outlined by MO HealthNet
ICD-10 Code(s):
Clinical Information:

TREATING PROVIDER INFORMATION	
Provider Specialty (please check): □ Chiropractor □ Physical Therapist □ Acupuncturist	
Provider Name:	**Provider NPI Number (if known):**
Provider Office Address:	
Phone Number:	**Fax Number:**

Please fax the completed form to **1-866-946-2052**. We will make a determination within 36 hours, including one business day, and send an authorization determination letter, via fax, with our determination to the treating provider.

An initial approval of 10 visits can be authorized through this process. The treating provider will need to request prior authorization from Missouri Care for any visits in excess of the initial approval.

©WellCare 2019