Provider Referral Form

BlueCross BlueShield Kansas

For disease and wellness management programs

Please provide as much of the following information as possible.

Section 1 – Patient Information

CLEAR DATA

First Name ____ MI

(____) ____-____ Home Phone Number

(____) ____-____ Cell Phone Number

Last Name

Best Time to Call

BCBSKS ID Number

____ /____ /____ Date of Birth

Preferred number to contact: ☐ Home ☐ Cell

Section 2 – Healthcare Provider Information

Health Care Provider Name

(____) ____-____ Provider Phone Number

(____) ____-____ Provider Fax Number

City

Provider Email

Preferred method of contact:
☐ Phone ☐ Fax ☐ Email

Section 3 – Biometric Screening Results

Blood Pressure

Blood Glucose

Total Cholesterol

HDL Cholesterol

LDL Cholesterol

Triglycerides

A1C

Other

Condition(s) being referred for:

☐ Asthma
☐ COPD
☐ Tobacco cessation
☐ High blood pressure
☐ Stress management
☐ Weight management
☐ Diabetes
☐ Heart failure
☐ Heart disease
☐ High cholesterol
☐ Maternity

Did the patient receive HealthyOptions materials during the visit? ☐ Yes ☐ No

Comments:

Form Completed By

____ /____ /____ Date Completed

Completed referral information may be sent via fax or secure email to:

Fax: 785-290-0825 Email: DMspecialists@bcbsks.com