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 _____

Comments:

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

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

An independent licensee of the Blue Cross Blue Shield Association.