Return this Form to *SoonerCare* Date: _____

☐ Retrospective Administrative Referral
Attn: Provider Services Phone: (800) 522-0114 option 1 or (405) 522-6205 option 1
Fax: (405) 530-3228 | Number of Pages: ____

☐ Prospective Administrative Referral
Attn: Care Management Phone: (877) 252-6002 | Fax: (405) 530-3217 | Number of Pages: ____

SOONERCARE REFERRAL REQUEST

Please complete the information below to document your attempts to obtain a referral from the PCP/CM. **Fax this completed form to SoonerCare.** Your referral request will be considered and you will receive written notice of approval or denial. Include any necessary medical records. **ALL PAYMENTS FOR SERVICES ARE SUBJECT TO COVERAGE LIMITATIONS UNDER THE CURRENT OKLAHOMA MEDICAID PROGRAM.**

RENDERING PROVIDER'S NAME:	
Provider #	Contact Person:
Address:	Telephone and Extension:
	Fax:

PATIENT INFORMATION: Completed by: ☐ Provider ☐ Provider Rep ☐ Care Management

Patient Name:	Phone: ( )	RID:

Type of service:	Diagnosis codes:	Date(s) of service:
☐ Office Visit ☐ Surgery ☐ Durable Medical Equipment ☐Other: _____ _____ _____	1._____ 2._____ 3._____	1. 2._____ 3._____

Notes/Other Information:

PCP/CM CONTACT INFORMATION: PCP/CM Name: Telephone: ( )

CONTACTS:

Date: Result of Contact:

Date:_____ Result of Contact:

****FOR OHCA USE ONLY****	☐ **MEDICAL** ☒ **ADMINISTRATIVE**	Approved by:
PCP/CM #	**Reason:**	Referral #