MultiCare Connected Care™

Provider Referral Waiver

Urgency of Request: ☐ Emergent ☐ Less than one week ☐ Routine ☐ Retroactive

Member Name: Last	First	M.I.	Gender M ☐ F ☐
Member Payer	Member ID Number	Date of Birth	
Subscriber Name (if different from member)	Subscriber ID Number (if different from member)		
Address (No P.O. Box)	Telephone		

Section 1: Treatment Information for Member

A. Referral Start Date	**B**. Referral End Date	**C**. Number of Visits
D. Condition Being Treated/Diagnosis		**E**. Diagnosis Code
F. Service Treatment Being Requested		**G**. CPT Code

H. Reason(s) for Out-of-Network Treatment/Service

☐ Service Not Available In-network

☐ Transition of Care

☐Other – Explain:

Section 2: Referring Provider

A. Provider Name: Last	First	M.I.
B. Provider Tax ID Number or SSN (mandatory)	C. Provider NPI number (optional)	
D. Provider Service Location Address (no P.O. box)		
E. Provider Phone	F. Provider Fax	

Section 3: Specialist Information

A. Specialist Name: Last	First	M.I.
B. Specialist Tax ID Number or SSN (mandatory)	C. NPI Number (optional)	
D. Specialist Service Location Address (no P.O. box)	E. Specialist Telephone Number	

Section 4: Signature of Referring Provider

Referring Provider Signature	Date

Please see reverse for decision and contact information

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Section 5: Decision (MCC Designee Completes this Section)		
A. Designee Name: Last	First	M.I.
B. ☐ Waiver Approved (with explanation and decision on ancillary services (lab, imaging, etc.) if applicable) ☐ Waiver Denied (with explanation):		
Signature	Date	

Please return completed form to MultiCare Connected Care by fax at (253) 864-4088

If you have any questions, please call (253) 545-2226

***Please note that waiver is not approved unless approved by MultiCare Connected Care