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: 405-213-1145 | 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.** One form per provider please. 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:

Rendering Provider #:	Contact Person:
Address:	Telephone and Extension:
	Fax:

Recipient Name:	Phone: ( )	Recipient ID #:

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

PCP/CM CONTACT INFORMATION:

PCP/CM Name:	Telephone: ( )

CONTACTS:

Name:	Date:	Result of Contact:
Name:	Date:	Result of Contact: