BlueCross BlueShield of Oklahoma

Limited Cost-sharing Referral Form

American Indians and Alaska Natives (AI/ANs) can get treatment from Indian health care providers at Indian Health Service, Tribal and Urban Indian facilities (I/T/Us).

AI/ANs on Health Insurance Marketplace limited cost-sharing plans who need services they cannot obtain through an I/T/U facility can get services at a different provider without paying anything out of pocket, if they have a referral.*

I/T/U facilities should use the following process to submit referrals for Blue Cross and Blue Shield of Oklahoma (BCBSOK) members to cover cost-sharing for medical care that is provided by non I/T/U facilities**:

Medical Referral

Referring I/T/U facility Information

I/T/U Facility Name:	
Contact Name:	Telephone Number:
Mailing Address:	
Email Address:	

Patient Information

Name:	DOB:
Group Number:	Member ID Number:

Referral Information

This referral is for all covered services from REFERRAL DATE:_____ through Dec. 31, 20 ___ (CURRENT YEAR)

Please fax the referral to our Payment Services Claims Processing area at **918-549-7777**.

Referrals can also be mailed to:

7777 East 42nd Place
Tulsa Oklahoma 74145
Attn: I/T/U Referral

* Members who receive services from an out-of-network provider may incur additional charges.
** For benefit questions, please contact the customer service number on the back of the member's ID card

Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross BlueShield of Oklahoma

Pharmacy Referral

Pharmacy claims are processed when the BCBSOK member fills the prescription at the pharmacy, so it is important for members to obtain an I/T/U referral before picking up a prescription.* Members may have to pay out of pocket for prescriptions filled without a referral.

Referring I/T/U facility Information

I/T/U Facility Name:	
Contact Name:	Telephone Number:
Mailing Address:	
Email Address:	

Patient Information

Name:	DOB:
Group Number:	Member ID Number:

Referral Provider Information

Pharmacy Name and Location/Address:

Number of Prescriptions needing Cost-Sharing Reduction and Length of Referral: How many medications are needing patient cost-sharing waived? Prescriptions needing cost-sharing reductions can only be set up with a claim on file.

Name of Medication:	Referral Effective / / through / /
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Please email the referral to **Retail_Service_Coordinators@bcbsil.com**.

* Some prescriptions may need prior authorization. This referral form is not a substitute for that process.
For benefit questions, please contact the customer service number on the back of the member's ID card.