Request for Chronic Pain Management Referral

DATE OF REQUEST_____

buckeye health plan

Phone **(614) 220-4900** Toll free **(866) 246-4359**

Member Name:	DOB:	Age:
ID # (SSN):	Eligibility:	
Request by MD: **( )**	Phone:	Contact Person:
Referred To: **( )**	Specialty:	Phone:
DX – Problem:	Appointment Date:	

Treatment reason/working diagnosis (attach medical records, notes, consults & test results):

Past Medical History (dates, Surgeries, if so Surgeon's name, treatment modalities, pt, etc.)

Goals (Function/Quality of life)

Treatment Plan (with timelines)

Services Requested (Evaluation, Injections, PT, Opiates, Follow Up/s)

To ensure a timely turn around on requested services Please fill out this form and fax the appropriate information/records pertaining to the services requested. **Fax numbers: SW Region: 866-529-0291; EC Region: 866-535-4083; NE Region: 866-529-0290; NW Region: 866-535-4084.**
Thank you,
Buckeye Referral Department