# Providence Health Plans
# Special Investigations Unit
# External Referral Form

## ABOUT YOU:

| | |
|---|---|
| Today's date | |
| Your full name | |
| Address | |
| Phone number | |
| Email address | |
| Are you a Providence Health Plan member? | |
| If yes, your member ID | |

## ABOUT ISSUE BEING REFERRED FOR REVIEW:

| | |
|---|---|
| Is the member involved a Medicare or Medicaid member? | |
| Describe the issue using as much detail as you can. Include date(s) of service, claim number, or other identifying details if possible | |
| Describe how you become aware of this issue | |
| If others may have information about this situation, please provide their names | |

**SEND BY MAIL OR FAX:** *Feel free to attach any supportive information, such as correspondence.*

| | |
|---|---|
| Mail | Providence Health Plans<br>Attention: SIU<br>P.O. Box 3150<br>Portland, OR 97208-4327 |
| Fax | (503) 574-8142 (secure fax line) |

Click to PRINT

Reset Form