Health Tradition Health Plan
A Mayo Clinic Health System Choice in Wisconsin

Mandatory fields are indicated with an *.
INCOMPLETE/ILLEGIBLE FORMS WILL BE RETURNED AND NOT PROCESSED

External Referral Request

Health Tradition Health Plan requires members to have a Plan-approved prior authorization for any covered services received at an out-of-network provider. Authorization must be approved prior to services being rendered out-of-network. This also includes Network Rental patients who are requesting in-network level benefits.

Note: Mayo Clinic is considered an out-of-network provider.

*First Name:_____ M.I. ____ * Last Name:_____ *DOB:_____
Address:_____
street city state zip
*Insurance Number: _____

* ☐ Premier ☐ Premier Plus ☐ BCare Standard ☐ BCare Benchmark ☐ BCare Core ☐ 65Plus
☐ Network Rental Custom Benefits Administrator Subscriber Name _____
☐ Network Rental UMR Subscriber Name _____

* **Diagnosis:**_____
(Include diagnosis code if available)

* Patient is being referred for consultation to:_____
(Include name of practitioner, facility, specialty and location)

* Indicate why patient needs cannot be met at Mayo Clinic Health System Franciscan Healthcare or at any other in-network facility:

* List date(s) and name(s) of specialist(s) that have previously evaluated patient for this diagnosis/condition:

Coverage for testing, procedures or treatment that can be done in-network, may not be approved out-of-network.

* List all services that the patient is being referred out-of-network for.

* PRINT Referring Provider : _____Date:_____

* PRINT Name of person completing:_____

PO Box 188 | La Crosse, WI 54602-0188 | Phone: 608-781-9692 | Toll Free: 888-459-3020 | Fax: 608-781-9654