



Referral Partner Authorization Form

Please fax this form to Health Care Services and to the specialist's office.

Instil Health Fax: 803-870-6200, email MED.AUTH.REQUEST@INSTILHEALTH.COM or call or 888-801-9617.

This Referral is only Valid if the listed specialist is a contracting Provider with Instil Health, identified through Light Beam and the service is a covered benefit, and the form is filled out completely.

1) Primary Care Provider:

Provider's Name: _____

Practice's Name: _____

Practice's Phone #: _____

Fax #: _____

2) Referred to Contracted InStil Provider:

Specialist's First Name: _____

Specialist's Last Name: _____

Practice's Name: _____

Patient Information

InStil Health ID#: _____

Name: _____

DOB: _____
Month Day Year

3) Was the provider identified through Light Beam? Yes [] No []

4) Type of Referral: (check only one)

[] Referral for office visits and office-based services/procedures that do not require prior authorization.

NOTE: Specialist must obtain prior approval from InStil Health for any services/procedures that require authorization. Call the prior authorization department at 888-801-9617.

[] Referral to Emergency Room Date of Service: _____ Name of Facility: _____

Important Information for Provider and Member:

- Referrals to all specialists are good for six months and include all medically necessary follow-up visits.
➤ Services provided to a patient who is no longer enrolled with InStil Health are not covered.
➤ Instil Health is not responsible for payment of non-covered benefits.
➤ Instil Health does not accept Retroactive referrals.
➤ Providers should only collect the applicable member copayment, coinsurance, and deductible.
➤ This form may not be used for mental health, durable medical equipment (DME), routine vision care, facility referrals, home care services or referrals to non-contracting providers.

5) Diagnosis, Symptoms or Problem:

Provider's Signature (or designee): _____ Date: _____