



# IDAHO Tribal Health Referral Form

This referral form offers protection from cost-sharing for tribal members being referred for items or services received outside of Indian health care providers, which include health programs operated by Indian Health Services, tribes and tribal organizations, and urban Indian organizations. For more information, visit [YourHealthIdaho.org/tribal-members](http://YourHealthIdaho.org/tribal-members).

Patient Name	Patient Date of Birth
Patient Subscriber ID Number	Name of Provider(s) Being Referred To
Address of Provider Being Referred To	
Description of Item/Service/Treatment Being Requested	
ICD-10 code	Description of Prescription(s) Being Requested
Dates of Service(s) From: _____ To: _____	Name of Indian Health Service Referring Provider
Address of Referring Provider	
Date of Referral (services must be started within 60 days of initial referral date)	

*This patient is a member of a Federally Recognized Indian Tribe and enrolled in a Qualified Health Plan (QHP) with limited cost-sharing protections or comprehensive cost-sharing protections under CFR § 156.410(b) (2) or (3) ("zero cost-sharing variation" or "limited cost-sharing variation"), which specifies that with a qualified referral a QHP issuer may not impose any cost-sharing on an Indian for Essential Health Benefits furnished through Purchased and Referred Care (formerly Contract Health Services).*

*With a qualified referral, the insurance carrier will reimburse the provider for the full contracted rate of the encounter; neither the Tribe nor the patient is responsible for any copay, coinsurance, or deductible. Please list the referring physician on all claims.*

Services must be started within 60 days of the initial referral date. Referral required for each health issue treatment sought for.

Prior Authorization may be required by the insurance carrier before receiving an item or service.

**PLEASE NOTE THIS IS NOT AN AUTHORIZATION FOR PAYMENT.**



# Your Health IDAHO Tribal Health Secondary Referral Form

This referral form offers protection from cost-sharing for tribal members being referred for items or services received outside of Indian health care providers, which include health programs operated by Indian Health Services, tribes and tribal organizations, and urban Indian organizations. For more information, visit [YourHealthIdaho.org/tribal-members](http://YourHealthIdaho.org/tribal-members).

Patient Name	Patient Date of Birth
Patient Subscriber ID Number	Name of Provider(s) Being Referred To
Address of Provider Being Referred To	
Description of Item/Service/Treatment Being Requested	
ICD-10 code	Description of Prescription(s) Being Requested
Dates of Service(s) From: _____ To: _____	Name of Indian Health Service Referring Provider
Address of Referring Provider	
Date of Referral (services must be started within 60 days of initial referral date)	

*This patient is a member of a Federally Recognized Indian Tribe and enrolled in a Qualified Health Plan (QHP) with limited cost-sharing protections or comprehensive cost-sharing protections under CFR § 156.410(b) (2) or (3) ("zero cost-sharing variation" or "limited cost-sharing variation"), which specifies that with a qualified referral a QHP issuer may not impose any cost-sharing on an Indian for Essential Health Benefits furnished through Purchased and Referred Care (formerly Contract Health Services).*

*With a qualified referral, the insurance carrier will reimburse the provider for the full contracted rate of the encounter; neither the Tribe nor the patient is responsible for any copay, coinsurance, or deductible. Please list the referring physician on all claims.*

Services must be started within 60 days of the initial referral date. Referral required for each health issue treatment sought for.

Prior Authorization may be required by the insurance carrier before receiving an item or service.

**PLEASE NOTE THIS IS NOT AN AUTHORIZATION FOR PAYMENT.**