

Referral Request for Cleveland Clinic Specialty Service Program (SSP)

Authorization is not a Guarantee of Payment Forms are
located on ohiohealthyplans.com
Fax: 330-656-2449
or 1-800-385-7085

| Member's Name / Last, First | Member's ID / Policy # | Date of Birth | Today's Date |
|-----------------------------|------------------------|---------------|--------------|
| | | | |

Date(s) of Service _____

Requesting Provider: (Full Name): _____ Specialty: _____

Ohio Healthy ID, Tax ID or NPI: _____

Phone: _____ Fax: _____

Contact Physician's Cell: _____

The following information is required to process your request:

Diagnosis Code(s): _____

Procedure Codes: _____/_____/_____/_____

Description: _____

First Available Physician (Full Name, Tax ID or NPI): _____

Previous or Preferred Physician (Full Name, Tax ID or NPI): _____

ohiohealthyplans.com or by calling the number listed on the back of the member's ID card

Person Completing this Form: _____

Phone: _____ / ext: _____ Fax: _____

