



## 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 Attention: SIU P.O. Box 3150 Portland, OR 97208-4327
Fax	(503) 574-8142 (secure fax line)