DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CLIENT MEDICAL MANAGEMENT PROGRAM

PRACTITIONER REFERRAL FORM

Recipient's Name: _____DMAS#: _____

Referred to: _____Date: _____

Purpose of Referral (check one):

_____Physician covering in absence of primary health care provider for (specify period of absence for up to 90 days)

_____

_____

_____See one time only for _____

_____See as needed for on-going treatment of _____

_____

(Referral for on-going treatment must be renewed at 90 day intervals.)

This recipient is restricted to me as his/her primary health care provider. Please refer to the billing chapter of your Medicaid Provider Manual for billing information. **This form must be part of your medical record. For reimbursement, a copy must be attached to every claim submitted on behalf of this recipient.**

If you wish to refer this patient to another source who will be billing Medicaid, you must obtain another referral form for that physician from me.

These referral provisions do not apply while the recipient is an inpatient in a hospital.

_____
Signature of Primary Health Care Provider

_____
Name of Primary Health Care Provider

Provider ID#: _____

Address: _____

_____

_____

Telephone # (____)_____

Instructions

The primary health care provider is the physician or clinic serving as the recipient's Client Medical Management (CMM) primary care physician (PCP). Use the correct PCP Provider ID number assigned to the recipient.

> NOTE: If the recipient is restricted to a clinic such as a Rural Health Clinic, the clinic physician serving as the primary physician completes and signs the form. The clinic name and number are listed under the physician's signature.

When a referral is made, you should provide the copies as follows:

- A copy is mailed to the referral physician or given to the recipient to take to the appointment with the referral physician.

- A copy is mailed or given to the recipient. The recipient should show their copy to the designated CMM pharmacy when filling a prescription from the referral physician or transportation provider if it is requested.

- A copy should be filed in the PCP's office record for the recipient.

Be sure to avoid these common errors:

- All fields on the form must be completed.
- Enter the complete 12 digit recipient Medicaid number.
- Referral date on line two must be on or prior to the date of service.
- Check the appropriate "Purpose of Referral".
- Use the correct PCP Provider ID number assigned to the recipient.
- Form must be signed by the primary care physician.