Michigan HealthCare Referral Form

Date Written: ☐☐ ☐☐ ☐☐☐☐ Revised Referral: ☐

Patient Name: _____ _____
LAST FIRST

MEMBER I.D. # / Suffix: ☐☐☐☐☐☐☐☐☐☐☐☐ DOB: ☐☐ ☐☐ ☐☐☐☐

Plan Name: Please see member ID card to verify product line coverage:
☐ CareSource MI ☐ HAP ☐ Health Plan of MI ☐ HealthPlus ☐ McLaren
☐ Midwest ☐ Molina ☐ PHP-MM ☐ Priority ☐ ProCare
☐ Total Health Care ☐ UPHP ☐ Other _____

Check if Applicable: ☐ **Worker's Comp.** ☐ **Auto Accident**

Referred By:
PCP Name: _____ _____
LAST FIRST
Phone Number: ☐☐☐ ☐☐☐ ☐☐☐☐ Tax ID #: ☐☐☐☐☐☐☐☐☐
Fax Number: ☐☐☐ ☐☐☐ ☐☐☐☐ Plan Assigned Provider ID#: ☐☐☐☐☐☐☐☐☐

Referred To:
Provider's Name: _____ _____
LAST FIRST
Phone Number: ☐☐☐ ☐☐☐ ☐☐☐☐ Tax ID #: ☐☐☐☐☐☐☐☐☐
Fax Number: ☐☐☐ ☐☐☐ ☐☐☐☐ Plan Assigned Provider ID#: ☐☐☐☐☐☐☐☐☐
Address: _____
STREET
_____ _____ ☐☐☐☐☐
CITY STATE ZIP CODE

ICD-9 Dx Code: ☐☐☐ ☐☐ Start Date: ☐☐ ☐☐ ☐☐☐☐ End Date: ☐☐ ☐☐ ☐☐☐☐

Location: ☐ **Provider Office -or-** ☐ **Outpatient Hospital -or-** ☐ **ER/UCC**
(submit separate referral for each location desired)

* Facility Number: ☐☐☐☐☐☐☐☐☐ Facility Name: _____

* Date of Service: ☐☐ ☐☐ ☐☐☐☐ **IF FOR AMBULATORY SURGERY, LIST CPT4 BELOW**

Specific Services Requested

Consult or Office Visit ☐ PLEASE SPECIFY THE NUMBER OF VISITS ☐☐☐

☐ Diagnostic Laboratory / Pathology **	☐ Audiology / Evaluation	☐ Ophthalmological Services
☐ Radiology / Imaging **	☐ Cast / Fracture Care	☐ Surgery ** ☐☐☐☐☐ (CPT code)
☐ Diagnostic / Therapeutic Studies **	☐ Oncology Services	**(complete location section above)**
☐ Injections & IV Therapy **	☐ Dialysis	☐ Pain Management **
☐ Allergy **	☐ OB / Perinatology	☐ Therapy ** ☐☐ Physical ☐☐ Occupational
		(indicate # of visits) ☐☐ Speech ☐☐ Cardiac
Optional: to authorize only specific services, write in CPT Codes here:	☐ Other ☐☐☐☐☐☐	☐ Other ☐☐☐☐☐☐
	☐ Other ☐☐☐☐☐☐	☐ Other ☐☐☐☐☐☐
	☐ Other ☐☐☐☐☐☐	☐ Other ☐☐☐☐☐☐

COMMENTS: _____

* Required for ER/UCC, Therapy & Outpatient services. ** Refer to specific plan instructions.

THIS REFERRAL DOES NOT GUARANTEE PAYMENT. PLEASE CONTACT THE HEALTH PLAN TO VERIFY MEMBER ELIGIBILITY AND COVERED BENEFITS.

Revised Feb. 2009