

Michigan HealthCare Referral Form

Date Written:

Revised Referral:

Patient Name: _____
LAST FIRST

MEMBER I.D. # / Suffix: DOB:

Plan Name: CareSource MI HAP Health Plan of MI HealthPlus McLaren
Please see member ID card to verify product line coverage: 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

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

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.