Michigan HealthCare Referral Form

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

Patient Name: _____ _____
LAST FIRST

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

Plan Name: ☐ BCN ☐ Blue Choice ☐ CAPE ☐ Care Choices ☐ GLHP ☐ HAP ☐ Health Plan of MI
Please see member ID card to verify product line coverage: ☐ M-CARE ☐ Molina ☐ OmniCare ☐ Total Health Care ☐ Wellness Plan ☐ 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** ☐ **Outpatient Hospital** ☐ **ER/UCC**

* 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 OFFICE VISITS ☐☐☐

☐ Diagnostic Laboratory / Pathology **	☐ Audiology / Evaluation	☐ Ophthalmological Services
☐ Radiology / Imaging **	☐ Cast / Fracture Care	☐ Surgery ** ☐☐☐☐☐ (CPT code) **(complete location section above)**
☐ Diagnostic / Therapeutic Studies **	☐ Oncology Services	
☐ Injections & IV Therapy **	☐ Dialysis	☐ Pain Management **
☐ Allergy **	☐ OB / Perinatology	☐ Therapy ** ☐☐ Physical ☐☐ Occupational ☐☐ Speech ☐☐ Cardiac **(indicate # of visits)**
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 March 2003