Maryland Uniform Consultation Referral Form

Date of Referral:

Patient Information:

Name: (Last, First, MI)

Date of Birth: (MM/DD/YY) | Phone: ( )

Member #:

Site #:

Carrier Information *(Please check One)*

Name:
- ❑ Employer Health Programs (EHP)
- ❑ Priority Partners MCO (PPMCO)
- ❑ Uniformed Services Family Health Plan (USFHP)
- ❑ Other: _____

Address: Johns Hopkins HealthCare, 6704 Curtis Court, Glen Burnie, MD 21060

Phone Number: 410-424-4480 or 800-261-2421

Fax Number: EHP 410-424-4890; PPMCO & USFHP 410-424-4603

Primary or Requesting Provider:

Name: (Last, First, MI) | Specialty:

Institution/Group Name: | Provider ID #: 1 | Provider ID #: 2 (If Required)

Address: (Street #, City, State, Zip)

Phone Number: ( ) | Facsimile/Data Number: ( )

Consultant/Facility Provider:

Name: (Last, First, MI) | Specialty:

Institution/Group Name: | Provider ID #: 1 | Provider ID #: 2 (If Required)

Address: (Street #, City, State, Zip)

Phone Number: ( ) | Facsimile/Data Number: ( )

Referral Information:

Reason for Referral:

Brief History, Diagnosis, and Test Results:

Services Desired: Provide Care as indicated:

- ❑ Initial Consultation Only
- ❑ Consult & Treat
- ❑ Diagnostic Test: (specify) _____
- ❑ Consultation With Specific Procedures: (specify) _____
- ❑ Specific Treatment: _____
- ❑ Global OB Care & Delivery
- ❑ Other: (Explain)

Place of Service:

- ❑ Office
- ❑ All Sites
- ❑ Outpatient Medical/Surgical Center *
- ❑ Radiology
- ❑ Laboratory
- ❑ Inpatient Hospital *
- ❑ Extended Care Facility *
- ❑ Other (Explain)

* (Specific Facility Must Be Named.)

Number of Visits: _____ . If Blank, 1 Visit is Assumed.

Authorization #: (If Required)

Referral is Valid Until: (Date) _____ . (See Carrier Instructions)

Signature: (Individual Completing This Form)

Authorizing Signature: (If Required)

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan / carrier.

White: Carrier; Yellow: Primary or Requesting Provider; Pink: Consultant/Facility Provider; Goldenrod: Patient

See Carrier/Plan Manual for Specific Instructions.