Maryland Uniform Consultation Referral Form

Date of Referral:	Carrier Information
Patient Information:	Name:
Name: (Last, First, MI)	Address:
Date of Birth: (MM/DD/YY) Phone: ( )	
Member #:	Phone Number:
Site #:	

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: **PULMONARY REHAB**
Institution/Group Name: **JOHNS HOPKINS BAYVIEW MEDICAL CENTER**	Provider ID #: 1 / Provider ID #: 2 (If Required)
Address: (Street #, City, State, Zip)	
Phone Number: (**410**) **550 5579**	Facsimile Data Number : (**410**) **550 1682**

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 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.

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