



Priority Partners Member Referral Form Instructions

PURPOSE

The Priority Partners Member Referral Form is used to assist providers with referring Priority Partners members that require additional services to the appropriate department. Johns Hopkins Health Plans will use this form to help members with receiving the service needed and provide adequate response to providers.

In order for a provider to disengage a member from the practice they must send a certified letter to the member and fax a copy to Priority Partners with the referral ([COMAR 10.67.05.03](#)).

INSTRUCTIONS

Date of Request: Enter today's date.

Member Information:

- **Member Name, Address, Phone #, DOB:** Enter the member's full name, address, phone number and date of birth.
- **Member ID#:** Indicate the member's ID number.

Referring Provider Information: Enter the referring provider's name, Tax ID/NPI, office contact name, providers email address, phone number and fax number.

Services Requested: Choose the referred department or program. Select the applicable service.

- Care Management/Population Health
- Pregnancy Services
- Special Needs
- Member Services Outreach

NOTE: A provider may request to reassign member(s) from their panel based on:

- *Continuous non-compliance with medical advice, diagnostic and treatment protocols*
- *Rude, disruptive, or abusive behavior with provider and staff*
- *Repeated failure to maintain three (3) or more scheduled appointments*
- *Assigned PCP panel closed*
- *Incorrect PCP assignment*

The provider must have exhausted all appropriate avenues including Priority Partners Member Services, social services, and local health department contact.

Additional Comments:

Priority Partners must have verbal permission to move a member to a new Primary Care Provider. Priority Partners will request this permission upon outreach to the member/responsible party.



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Priority Partners Member Referral Form

FOR PROVIDER USE ONLY

Complete this form and fax to the appropriate service department using the fax numbers below. You will receive a response within 10 business days.

*Required information

*Date of Request: _____

Member Information:		Referring Provider Information:	
*Member name:	*Member ID#:	*Provider name:	*Tax ID or NPI:
*Address:		*Office contact name:	
*City, State, Zip:		Provider email:	
*Phone #:	*DOB:	*PCP phone and fax:	
Services Requested: Fill out the section and fax to the appropriate department. For questions about a service or program, contact the appropriate department using the provided phone or fax number.			
Care Management (P) 800-557-6916 (F) 410-424-4885 <input type="checkbox"/> Peds & Adults – Chronic Conditions		Health Education: (P) 800-557-6916 (F) 410-424-4885 Topic:	
Special Needs: (P) 410-424-4965 (F) 410-424-4887 <input type="checkbox"/> Translation/Interpretation Services <input type="checkbox"/> Homelessness <input type="checkbox"/> Foster Care Member <input type="checkbox"/> End-Stage Renal Disease <input type="checkbox"/> Other		Pregnancy Services: (P) 800-557-6916 (F) 410-424-4885 <input type="checkbox"/> High Risk Pregnancy <input type="checkbox"/> Adolescent (Under 18) <input type="checkbox"/> Has Chronic Disease <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> History of Pre-Term Birth	
Member Services Outreach: (P) 844-288-9593 (F) 410-424-4030 Has member missed (3) three consecutive appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Regular appointment including sick visit <input type="checkbox"/> Missed appointment - Provide appropriate HEDIS measure _____ <input type="checkbox"/> Reassignment Review - Requires copy of certified letter to member explaining your disengagement, submitted with this form Reassignment Review Reason: <input type="checkbox"/> Continuous non-compliance with medical advice, diagnostic and treatment protocols <input type="checkbox"/> Rude, disruptive, or abusive behavior with provider and staff <input type="checkbox"/> Repeated failure to maintain three (3) or more scheduled appointments <input type="checkbox"/> Assigned PCP panel closed <input type="checkbox"/> Incorrect PCP assignment			
New Member Welcome: (P) 800-848-1196 Did member miss the initial New Member Appointment with PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No			
REM Program (F) 410-762-1638 <input type="checkbox"/> Possibly Eligible for the REM program			