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.

JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100
Hanover, MD 21076

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
☐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*
☐Interpretation Services
☐Homelessness
☐Foster Care Member
☐End-Stage Renal Disease
☐Other

Pregnancy Services: *(P) 800-557-6916 (F) 410-424-4885*
☐High Risk Pregnancy
☐Adolescent (Under 18)
☐Has Chronic Disease
☐Substance Use Disorder
☐History of Pre-Term Birth

Member Services Outreach: (P) 844-288-9593 (F) 410-424-4030
Has member missed (3) three consecutive appointments? ☐Yes ☐No
☐Regular appointment including sick visit
☐Missed appointment - Provide appropriate HEDIS measure__________________
☐Reassignment Review - Requires copy of certified letter to member explaining your disengagement, submitted with this form

Reassignment Review Reason:
☐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

New Member Welcome: (P) 800-848-1196
Did member miss the initial New Member Appointment with PCP? ☐Yes ☐No

REM Program (F) 410-762-1638
☐Possibly Eligible for the REM program