## Maryland Uniform Consultation Referral Form

### Carrier Information:
- Name: □Advantage MD  □Employer Health Programs (EHP)
- □Priority Partners MCO (PPMCO)  □Uniformed Services Family Health Plan (USFHP)  □Other _____
- Address: Johns Hopkins HealthCare LLC
- 7231 Parkway Drive, Suite 100
- Hanover, MD 21076
- Phone Number: Advantage MD 877-293-4998
- EHP, PPMCO, USFHP 800-261-2421 or 410-424-4480
- Fax #:
- Referral is Valid Until: (Date) ______________.  (See Carrier Instructions)
- Other: (Explain) * (Specific Facility Must be Named.)
- Number of Visits: _______.  If Blank, 1 Visit is Assumed.
- Authorization #: (If Required)
- Signature: (Individual Completing This Form)
- Authorizing Signature: (If Required)

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

See Carrier/Plan Manual for Specific Instructions.

### Date of Referral:

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

### 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: *(Include ICD-9)*

### Services Desired:

Provide Care as indicated:
- □ Initial Consultation Only:
- □ Diagnostic Test: (specify) ______________
- □ Consultation With Specific Procedures: (specify) ______________
- □ Specific Treatment: ______________
- □ Global OB Care & Delivery
- □ Other: (Explain) ______________

Place of Service:
- □ Office
- □ Outpatient Medical/Surgical Center *
- □ Radiology  □ Laboratory
- □ Inpatient Hospital *
- □ Extended Care Facility *
- □ Other: (Explain) ______________  * (Specific Facility Must be Named.)

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.