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:

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

Facsimile/Data #: Advantage MD 410-424-4036
EHP 410-424-4800
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: *(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.)

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.