

Maryland Uniform Consultation Referral Form

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|--------------------------------------------------------|---------------|-----------------------------|--|
| Date of Referral: | | Carrier Information: | |
| Patient Information: Name: (Last, First, MI) | | Name: | |
| | | Address: | |
| Date of Birth: (MM/DD/YY) | Phone: () | Phone Number: () | |
| Member #: | | Facsimile/Data #: () | |
| 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: | |
| 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: <i>(Include ICD-9)</i> | | |
| | | |
| Services Desired: Provide Care as indicated: <input type="checkbox"/> Initial Consultation Only: <input type="checkbox"/> Diagnostic Test: (specify) _____ <input type="checkbox"/> Consultation With Specific Procedures: (specify) _____ <input type="checkbox"/> Specific Treatment: _____ <input type="checkbox"/> Global OB Care & Delivery <input type="checkbox"/> Other: (Explain) _____ | Place of Service: <input type="checkbox"/> Office <input type="checkbox"/> Outpatient Medical/Surgical Center * <input type="checkbox"/> Radiology <input type="checkbox"/> Laboratory <input type="checkbox"/> Inpatient Hospital * <input type="checkbox"/> Extended Care Facility * <input type="checkbox"/> 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.