Maryland Uniform Consultation Referral Form

Date of Referral:	**Carrier Information:**
Patient Information:	Name:
Name: (Last, First, MI)	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: *(Include ICD-9)*

Services Desired: Provide Care as indicated:	**Place of Service:**
☐ Initial Consultation Only:	☐ Office
☐ Diagnostic Test: (specify) _____	☐ Outpatient Medical/Surgical Center *
☐ Consultation With Specific Procedures: (specify) _____	☐ Radiology ☐ Laboratory
_____	☐ Inpatient Hospital *
☐ Specific Treatment: _____	☐ Extended Care Facility *
☐ Global OB Care & Delivery	☐ Other: (Explain)
☐ 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.