CareFirst
Community Health Plan
Maryland

Provider Referral Form

For help with this form, please call the Quality Services Department Monday through Friday from 8am to 4:30pm at 1-410-921-2130. Once the form is complete, fax it to 1-410-779-3957.

INSTRUCTIONS—Please complete all fields below

Client's Name		Date of Referral
Medicaid ID Number		
Date of Birth	Telephone Number	
Client's Address		
Client's City	Client's State	Zip Code

REFERRAL TO

Name of Member's Insurance Company	Member's Insurance ID Number	
Service Provider's Name	Service Provider's Phone Number	
Service Provider's Address		
Service Provider's City	Service Provider State	Service Provider Zip Code

REFERRAL BY

Service Provider's Name	Service Provider's Phone Number
Service Provider's Address	
Service Provider's Reply (summary of findings, diagnosis, recommendations, comments, as appropriate):	

Reason for Outreach Referral

- Assist/Educate with transportation to medical appointment
- Assist/educate with location of PCP
- Educate about MCO processes
- Need contact from Special Needs Coordination (Please specify reason)
- Provide information about community-based services for:
- Assist Provider with scheduling appointment
- Follow up on repeated ER usage/educate member to use PCP for care
- Follow up on repeated missed appointments (List dates)
- Other

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