

This form is a suggested format for written referrals. Its use is optional. Referrals must be documented in the patient's medical record. This form does not need to be submitted with the claim for the rendered service.

**REFERRAL FOR HOOSIER HEALTHWISE MANAGED CAREMEMBER**

Date: \_\_\_\_\_

To: \_\_\_\_\_

From: \_\_\_\_\_

Provider #: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Patient's Name \_\_\_\_\_

Medicaid or RID #: \_\_\_\_\_

Purpose of Referral: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Extent of Referral (Check one):

One time only

As needed for treatment. (A new form or verbal authorization must be obtained prior to every calendar quarter).

Other, please specify:

This member is enrolled with me as his/her Primary Medical Provider (PMP). Please keep me informed of the disposition of the patient following your contact. As the patient's PMP, my medical records must reflect a complete health history. If you wish to refer this patient to another treatment source that will be billing Medicaid, please contact me.

By: \_\_\_\_\_

Primary Medical Provider