

# Maryland Uniform Consultation Referral Form

<b>Date of Referral:</b>	<b>Carrier Information</b>
<b>Patient Information:</b>	<b>Name:</b> Maryland Physicians Care MCO
<b>Name:</b> (Last, First, MI)	<b>Address:</b> 509 Progress Drive, Suite 117 Linthicum, MD 21090
<b>Date of Birth:</b> (MM/DD/YY) <b>Phone:</b> ( )	<b>Phone Number:</b> 800-953-8854
<b>Member #:</b>	
<b>Site #:</b>	

## Primary or Requesting Provider:

<b>Name:</b> (Last, First, MI)	<b>Specialty:</b>
<b>Institution/Group Name:</b>	<b>Provider ID #: 1</b> <span style="float: right;"><b>Provider ID #: 2 (If Required)</b></span>
<b>Address:</b> (Street #, City, State, Zip)	
<b>Phone Number:</b> ( )	<b>Facsimile Data Number :</b> ( )

## Consultant/Facility Provider:

<b>Name:</b> (Last, First, MI)	<b>Specialty:</b>
<b>Institution/Group Name:</b>	<b>Provider ID #: 1</b> <span style="float: right;"><b>Provider ID #: 2 (If Required)</b></span>
<b>Address:</b> (Street #, City, State, Zip)	
<b>Phone Number:</b> ( )	<b>Facsimile Data Number :</b> ( )

## Referral Information:

<b>Reason for Referral:</b>	
<b>Brief History, Diagnosis, and Test Results:</b>	
<b>Services Desired:</b> Provide Care as indicated: <input type="checkbox"/> Initial Consultation Only <input type="checkbox"/> Consult & Treat <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) _____	<b>Place of Service:</b> <input type="checkbox"/> Office <input type="checkbox"/> All Sites <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.)
<b>Number Visits:</b> _____ If Blank, 1 visit is Assumed.	<b>Authorization #:</b> _____ (If Required)
<b>Referral is Valid Until:</b> (Date) _____ (See Carrier Instructions)	
<b>Signature:</b> (Individual Completing This Form)	<b>Authorizing Signature:</b> (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.**