Maryland Uniform Consultation Referral Form

Date of Referral:	Carrier Information
Patient Information:	Name: Maryland Physicians Care MCO
Name: (Last, First, MI)	Address:1 1201 Winterson Rd., 4th Floor Linthicum, MD 21090
Date of Birth: (MM/DD/YY) Phone: ( )	Phone Number: 800-953-8854
Member #:	
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:

Services Desired:

Provide Care as indicated:

- ❑ Initial Consultation Only
- ❑ Consult & Treat
- ❑ Diagnostic Test: (specify)________________________________
- ❑ Consultation with Specific Procedures: (specify) ____________
- ❑ Specific Treatment: ________________________________
- ❑ Global OB Care & Delivery:
- ❑ Other: (Explain)

Place of Service:

- ❑ Office
- ❑ All Sites
- ❑ Outpatient Medical/Surgical Center*
- ❑ Radiology
- ❑ Laboratory
- ❑ Inpatient Hospital*
- ❑ Extended Care Facility*
- ❑ Other (Explain)

*(Specific Facility Must Be Named.)

Number 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.

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