

Pro Care Referral Form

Choose One: Pro Care Medicaid Health Choice ABW

CLAIMS SUBMITTED MORE THAN ONE (1) YEAR AFTER THE DATE OF SERVICE ARE NOT PAYABLE

REFERRED TO	FACILITY OR PROVIDER				MEMBER INFORMATION			
FACILITY OR PROVIDER ADDRESS					MEMBER NO.			
CITY	ZIP	PHONE NO.	FAX NO.	BIRTHDATE				
REFERRED BY	PRIMARY CARE PHYSICIAN			LAST NAME		FIRST		
PHYSICIAN ADDRESS								
CITY	ZIP	PHONE NO.	FAX NO.	OTHER INSURANCE NAME OF CARRIER		CONTRACT NO.		

DIAGNOSIS:	DIAGNOSIS CODE
	1
	2
Please identify in detail the treatment and / or services being authorized	PROCEDURE CODE
	1
	2

TO THE CONSULTANT

THIS REFERRAL IS FOR:

SINGLE VISITS:

- Consultation
- X-Ray
- Laboratory (*must use Quest Labs)

MULTIPLE VISITS:

- # of visits _____
- X-Ray
- Laboratory (*must use Quest Labs)

Specialist Physicians should contact PCP before writing scripts

Start Date _____

End Date _____

SIGNATURE OF PRIMARY CARE PHYSICIAN

DATE

If services beyond those listed on this form are needed, you must contact the Primary Care Physician for additional authorization. An PCHP authorization number must be obtained for facility admission and facility outpatient surgery; and health agency services and DME. **FAILURE TO OBTAIN AUTHORIZATION WILL RESULT IN PAYMENT DELAYS OR DENIALS.** If start and end dates are left blank, referral defaults to 1 visit and 30 days.

Provider agrees to look only to the Plan for compensation for services rendered to Member when such services are covered by the applicable plan contract. **Provider agrees not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge or have any recourse against Member or persons acting on behalf of Member (other than Plan).**

NOTE: This consultation referral form is only valid if the member has the Benefit that covers stated condition. The member must also be eligible on the date of service. If it is determined that the member is not eligible on date of service, resulting claims will be rejected.

OTHER INFORMATION

Hard Copy Claims Mail To: Pro Care P.O. Box 3160, Detroit, MI 48203

Telephone: (877) 255-3055 • Fax: (313) 921-0841