

# Maryland Uniform Consultation Referral Form

<b>Date of Referral:</b>	<b>Carrier Information:</b>	
<b>Patient Information:</b>	Name:	
Name: (Last, First, MI)	Address:	
Date of Birth: (MM/DD/YY)      Phone: (    )	Phone Number: (    )	
Member #:	Facsimile/Data #: (    )	
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: <i>(Include ICD-9)</i>		
<b>Services Desired:</b> Provide Care as indicated: <input type="checkbox"/> Initial Consultation Only: <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"/> 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.)	
Number of Visits: _____ If Blank, 1 Visit is Assumed.	<b>Authorization #:</b> (If Required)	Referral is Valid Until: (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.**