MEDICAID CMHC HEALTH HOME REFERRAL FORM

I am referring _____, born on _____, to _____
Recipient Name Date of birth Provider

for medically necessary Medicaid covered services for:_____.
Timeframe: one (1) year or less

Health Home Provider Name/Phone Number | Health Home Provider Medicaid ID #

NPI (required) and/or Taxonomy code (if applicable) | BNPI (required for payment)

Health Home Provider Mailing Address | Fax

Designated Provider Signature/Authorization | Date

Referral to _____ for medically necessary primary care
Provider

for:_____.
Timeframe: one (1) year or less

Attending Physician Signature/Authorization | Date

Signature of Specialty Provider | Date

Signature of Further Specialty Provider | Date

Signature of Further Specialty Provider | Date

After each service is provided, medical record information should be communicated back to the Health Home. Send a copy of this form back to the provider to assist in care coordination.