MEDICAID 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
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.