COMMUNITYCARE REFERRAL/AUTHORIZATION FORM

(1) Patient Name:	(2) Medicaid ID Number:
(3) Address:	(4) Date of Birth:
	(5) Telephone Number:

(6) REFERRED TO:

Purpose For Referral/Authorization (select and complete section 7, 8 OR 9)

☐ **(7) Medical Referral**

(7a) Diagnosis/Suspected Condition: ____________________

(7b) Scope of Referral/Comments: ____________________

(7c) Effective Date: From: ____________ Through: ____________

(not to exceed 6 months except as specified on page 5-3 of the CommunityCARE Handbook)

(7d) ☐ **Approved**: Referral #: ____________ NPI # ____________ Taxonomy # ________

(7e) ☐ **Denied:** Reason ____________________

☐ **(8) Post ER Authorization**

(8a) Presenting Symptoms: ____________________

(8b) ☐ **Approved**: Authorization #: ____________ NPI # ____________ ____Taxonomy# ________
Effective Date/Date of Service: ____________

(8c) ☐ **Denied** (Presenting symptoms do not meet prudent layperson standard)

(8d) ☐ **Need More Information** (specify what additional information is needed): ____________

☐ **(9) Non-Medical Authorization**

(9a) ☐ Administrative (9b) ☐ Transitional **(PCP Change-not to exceed 2 months)**

Effective Date: From: ____________ Through: ____________

(9c) Authorization Number: ____________ NPI # ____________ Taxonomy# ________

(10) CommunityCARE PCP Name: ____________________

(11) Address: ____________________ (12)Telephone Number: ____________

NOTE: If enrolled in CommunityCARE as a group, indicate group name; if enrolled as an individual provider, indicate individual physician name.

(13) PCP Signature: ____________________ (14) Issue Date: ____________

Unauthorized use of a CommunityCARE PCP's provider number for billing purposes shall result in recovery by the Medicaid Program of all unauthorized reimbursements from the unauthorized billing physician/agency. Submission of a fraudulent claim is punishable by a fine and/or imprisonment.

INSTRUCTIONS FOR COMPLETING THE COMMUNITYCARE REFERRAL/AUTHORIZATION FORM

FIELD NO. 1	**PATIENT NAME**	Enter the patient name exactly as it appears on the claim form.
FIELD NO. 2	**MEDICAID I.D. NUMBER**	Enter the patient's 13-digit Medicaid number.
FIELD NO. 3	**ADDRESS**	Enter the patient's address
FIELD NO. 4	**DATE OF BIRTH**	Enter the patient's date of birth in MMDDYYYY format.
FIELD NO. 5	**TELEPHONE NUMBER**	Enter the patient's telephone number.
FIELD NO. 6	**REFERRED TO (PROVIDER'S NAME)**	Enter the full name of the provider the patient is being referred to.
FIELD NO. 7	**MEDICAL REFERRAL**	Check this box if the PCP is referring the recipient to another provider for care.
	(7a) Diagnosis/Suspected Condition	Enter the patient's diagnosis or suspected condition
	(7b) Scope of Referral/Comments	Enter any restrictions or conditions of the referral. i.e. limited by a specific number of visits, specific condition, etc
	(7c) Effective Date	Enter the "from" and "through" date for the referral. Not to exceed 6 months, except as specified in the CommunityCARE Handbook.
	(7d) Approved	If the request is approved, check this box and enter the appropriate referral number, NPI number and taxonomy (if applicable)
	(7e) Denied	If the request is denied, check this box and give a reason for the denial
FIELD NO.8	**POST ER AUTHORIZATION**	Check this box if the provider is requesting post-authorization of an ER visit.
	(8a) Presenting Symptoms	Enter a **DETAILED** explanation of the patient's **PRESENTING SYMPTOMS**, including severity, duration, etc. Simply listing symptoms such as "fever" or "rash" is not sufficient. **DO NOT ENTER DIAGNOSIS.**
	(8b) Approved	If the PCP approves the visit, (s)he should check this box and enter the appropriate authorization number , NPI number, taxonomy (if applicable,) and the effective date.
	(8c) Denied	If the PCP denies the visit, (s)he should check this box.
	(8d) Need More Information	The PCP should check this box if information on presenting symptoms is not sufficient to determine whether the Prudent Layperson Standard was met. The PCP should then indicate what additional information is needed
FIELD NO. 9	**NON-MEDICAL AUTHORIZATION**	Check either 9a or 9b, then enter the appropriate authorization number
	(9a) Administrative Authorization	See the Administrative Authorization section of the CommunityCARE Provider Training packet for appropriate use.
	(9b) Transitional Authorization	To be issued when the recipient has requested a change of PCP that is not yet reflected in the Medicaid Eligibility Verification systems. **Transitional Authorizations should not be written for more than 60 days.**
	(9c) Authorization Number	Check this box and enter the appropriate authorization number, NPI number and taxonomy (if applicable)
FIELD NO. 10	**COMMUNITYCARE PCP NAME**	Enter the referring CommunityCARE provider's name. (If enrolled as a group, indicate group name; if enrolled as an individual provider, indicate individual physician name).
FIELD NO. 11	**ADDRESS**	Enter the referring CommunityCARE provider's physical address.
FIELD NO. 12	**PHONE NUMBER**	Enter the referring CommunityCARE provider's phone number.
FIELD NO. 13	**PCP SIGNATURE**	Enter the signature of the primary care provider authorizing the referral.
FIELD NO. 14	**ISSUE DATE**	Enter the date of issue for the referral/authorization

IF YOU HAVE ANY QUESTIONS CONCERNING THE PROCESS TO COMPLETE THE COMMUNITYCARE REFERRAL FORM, PLEASE CONTACT UNISYS PROVIDER RELATIONS (800) 473-2783.