MICHIGAN STATE UNIVERSITY

Medicaid HMO Non-Contracted Specialty Access Form

East Lansing Referral Phone Number 517-432-2366 East Lansing Referral Fax Number 517-432-6692

PLEASE CHECK HEALTH PLAN
[ ] BlueCaid of Michigan
[ ] CareSource
[ ] Great Lakes Health Plan, Inc.
[ ] Health Plan of Michigan, Inc.
[ ] HealthPlus Partners, Inc.
[ ] Midwest Healthcare of Michigan
[ ] Molina Healthcare of Michigan
[ ] OmniCare Health Plan
[ ] Priority Health Government Programs, Inc
[ ] Procare Health Plan
[ ] Total Health Care
[ ] Upper Peninsula Health Plan

PLEASE CHECK SPECIALTY
[ ] Bleeding & Clotting Disorder
[ ] Cardiology
[ ] Endocrinology/Diabetology
[ ] General Surgery
[ ] Genetics
[ ] Hematology
[ ] Infectious Disease
[ ] Lymphedema
[ ] Neurology
[ ] Neuro-ophthalmology
[ ] OB/GYN
[ ] Ophthalmology
[ ] Oncology
[ ] Orthopedics
[ ] Pulmonary
[ ] Sports Medicine
[ ] Urology

Pediatric Specialties
[ ] Bleeding & Clotting Disorder
[ ] Genetics
[ ] Hematology/Oncology
[ ] Infectious Disease
[ ] Neurology
[[Orthopedics
[ ] Pulmonary
[ ] Urology

Radiology
[ ] CT
[ ] General
[ ] PET
[ ] MRI

1. PROVIDER INFORMATION:

Primary Care Physician: Phone: Fax:

Address: City: Zip: County:

Referring Physician (if not PCP): Phone: Fax:

Address City: Zip: County:

2. REFERRAL REASON:

[ ] Continuation of care
[ ] Specialty not available in-network
[ ] In-network specialist clinically unable to treat
[ ] **In network specialist have been contacted and are not willing to see the member.**

3. PATIENT INFORMATION:

Last Name: First Name: Referral Date:

Sex: [ ] Female [ ] Male Date of Birth:

Address: City: Zip: County:

Phone: HM: WK: Cell: Alt:

Parent/Guardian Contact Info (if applicable): Name(s):

Phone: HM: WK: Cell: Alt:

4. HEALTH PLAN PRELIMINARY SERVICE REQUESTED:

Health Plan ID #: Medicaid Recipient ID#

Service Type:

Number of Visits: Start Date: End Date:

Diagnosis/ ICD-9: ____ Procedures/CPT: ____

Symptoms: ____

Health Plan Authorization: Plan Authorization #

Completed By: Contact Phone #:

6/4/09