



Mercy Care Plan Referral Form

Referring Provider: Complete this form and forward to the provider's office to whom you are referring the member. Retain a copy of the completed form in the member's medical record.

Date of Request:			
Member Information			
Name:		DOB:	ID Number:
Address:		Address Confirmed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Telephone Number:			
Referring Provider Information (Refer From) <small>(Provider who is initiating the referral)</small>			
Name of Referring Physician:			
Name of Person Completing Referral Form:			
Clinic/Office Address:			
Telephone Number:		Fax Number:	
Recipient of Referral (Refer To) <small>(Name of provider to whom the member is being referred)</small>			
Name of Recipient Provider:			
Clinic/Office Address:			
Telephone Number:		Fax Number:	
Date(s) of Service:			
Requested Service <small>(Description of the service that is being requested by the referring provider)</small>			
<input type="checkbox"/> Evaluation/Consultation Only		<input type="checkbox"/> Evaluation and Treatment	
Diagnosis:		<input type="checkbox"/> Follow-Up Visit(s):	
Clinical Summary/Remarks:			
NOTE: To ensure proper payment of rendered services, the recipient of this referral must verify member eligibility on the date of service.			