home state health

MEDICAID REFERRAL FORM

Complete and **Fax** to: 1-855-286-1811
Or **Call**: 1-855-694-4663

All required fields must be filled in as incomplete forms will be rejected.

Referrals may be submitted via the Home State Health Provider Portal or called in to **1-855-694-4663**

***INDICATES REQUIRED FIELD**

MEMBER INFORMATION

*Date of Birth (MMDDYYYY)

*Medicaid/Member ID

Last Name, First

REQUESTING PROVIDER INFORMATION

*Requesting NPI

*Requesting TIN

Requesting Provider Contact Name

Requesting Provider Name

Phone

*Fax

SPECIALIST REFERRING TO:

*Servicing NPI

*Servicing TIN

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

REFERRAL REQUEST:

*Procedure Code: 9 9 2 1 1 (CPT/HCPCS) A F (Modifier)

***Start Date** (MMDDYYYY)

*Diagnosis Code (ICD-10)

Total Units/Visits/Days

**The above procedure code is for the referral only. Providers should be sure that the claim for the office visit is billed using the correct office visit procedure code.

***OUTPATIENT SERVICE TYPE** (Enter the Service type number in the boxes) 9 9 9 **Referral**

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION OR DENIAL.

Disclaimer: A referral is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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