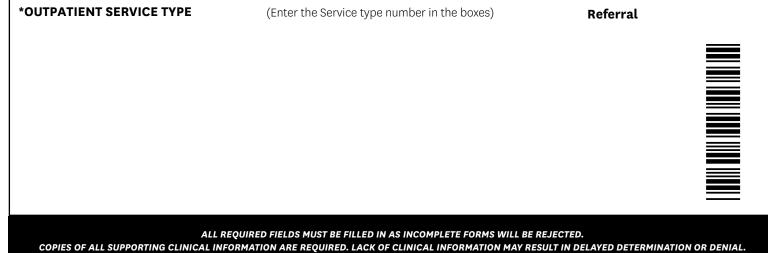


## MEDICAID REFERRAL FORM

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				
*Date of Birth				
*Medicaid/Member ID		Last Name, First	(MMDDYYYY)	
REQUESTING PROVIDER INFORMAT	ION			
*Requesting NPI	*Requesting TIN	Requesting F	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	
*Group NPI	*Group Name			
REFERRAL REQUEST:		*Start Date		*Diagnosis Code
		(MMDDYYYY)		(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.				
		vice type number in the boxes)	Refe	



Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.