1100 Circle 75 Parkway, Suite 1100, Atlanta, GA, 30339 • 1-800-504-8573

Community Health Services Department Provider Referral Form

(Formerly Member Connections™)

Use this form to refer a member to Peach State Health Plan for a visit from a Community Health Services Representative.

Date: _____ Medicaid Number: _____

Member Name: _____ Member Contact Number: _____

Member Address: _____

_____

Provider: _____ Office Contact: _____

Provider Address: _____

_____

Provider Contact Number: _____ Provider Fax Number: _____

Please check the reason for referral: (Medical or Behavioral)

- ☐ Non Adherence to treatment plan (medication, outpatient follow up)
- ☐ Social Determinants (transportation, food insecurities, education, utility assistance)
- ☐ ED Diversion (three or more ED visits within 90 days)
- ☐ Recent inpatient
- ☐ Identified Health Care Gaps (missed appointments, care coordination)

Reason type:

- ☐ Standard (within 5 business days)
- ☐ Expedited (within 3 business days)
- ☐ Urgent (within 24 hours)

Please give details as to the reason for the referral and your expectation of the Commmunity Health Sevices visit:

Please fax the completed form to a Peach State Health Plan Community Health Services Representative at: 1-866-532-8835.

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