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peach state health plan

MemberCONNECTIONS™ Provider Referral Form

Use this form to refer a member to Peach State Health Plan for a visit from a MemberConnections 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 the referral:

- ☐ Non-compliance
- ☐ Social Issues (i.e. homelessness, transportation, domestic violence, or drug abuse)
- ☐ Missed Appointments (minimum of three)
- ☐ Recent Medical Encounters
- ☐ Recent Hospitalizations
- ☐ Other; please explain

Reason Type:

- ☐ Standard (within 5 business days)
- ☐ Expedited (within 2 business days)
- ☐ Urgent (within 24 hours)

Please give details as to the reason for the referral and your expectation of the MemberCONNECTIONS visit: _____

_____

_____

_____

_____

_____

Please fax the completed form to a Peach State Health Plan MemberCONNECTIONS Representative at (866) 532-8835