1100 Circle 75 Parkway, Suite 1100 Atlanta, GA 30339 ·1-800-504-8573 · www.pshp.com

COMMUNITY HEALTH SERVICES DEPARTMENT PROVIDER REFERRAL FORM

(Formerly MemberConnections™)

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 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 Community Health Services visit:

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

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