# Maryland Uniform Consultation Referral Form

## Date of Referral:

### Patient Information:

- **Name:** (Last, First, MI)
- **Date of Birth:** (MM/DD/YY)
- **Member #:**
- **Site #:**

### Carrier Information:

- **Name:**
- **Address:**
- **Phone Number:** ( )
- **Facsimile/Data #:** ( )

## Primary or Requesting Provider:

- **Name:** (Last, First, MI)
- **Specialty:**
- **Institution/Group Name:**
- **Provider ID #: 1**
- **Provider ID #: 2 (If Required)**
- **Address:** (Street #, City, State, Zip)
- **Phone Number:** ( )
- **Facsimile/Data Number:** ( )

## Consultant/Facility Provider:

- **Name:** (Last, First, MI)
- **Specialty:**
- **Institution/Group Name:**
- **Provider ID #: 1**
- **Provider ID #: 2 (If Required)**
- **Address:** (Street #, City, State, Zip)
- **Phone Number:** ( )
- **Facsimile/Data Number:** ( )

## Referral Information:

- **Reason for Referral:**
- **Brief History, Diagnosis, and Test Results:** *(Include ICD-9)*

## Services Desired:

- Provide Care as indicated:
  - Initial Consultation Only:
  - Diagnostic Test: (specify) __________
  - Consultation With Specific Procedures: (specify) __________
  - Specific Treatment: __________
  - Global OB Care & Delivery
  - Other: (Explain) __________

## Place of Service:

- Office
- Outpatient Medical/Surgical Center *
- Radiology
- Laboratory
- Inpatient Hospital *
- Extended Care Facility *
- Other: (Explain) * (Specific Facility Must be Named.)

## Number of Visits:

- If Blank, 1 Visit is Assumed.

## Authorization #:

- (If Required)

## Referral is Valid Until: (Date) __________.

(See Carrier Instructions)

## Signature:

- (Individual Completing This Form)

## Authorizing Signature:

- (If Required)

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Referral certification is not a guarantee of payment. Payment of benefits is subject to a member’s eligibility on the date that the service is rendered and to any other contractual provisions of the plan / carrier.

See Carrier/Plan Manual for Specific Instructions.