IDAHO DEPARTMENT OF HEALTH & WELFARE

To submit referrals electronically, sign into your Trading Partner Account through Health PAS Online at www.idmedicaid.com

Primary Care Referral Form

(PLEASE PRINT CLEARLY)

Participant Information:

Date_____ Participant Name _____

Participant Medicaid #: _____ Participant Date of Birth:_____

Referring Primary Care Provider:

Primary Care Provider Organization Name: _____

Provider Billing NPI#_____

Specific Referring Provider Name _____

Primary Care Provider Clinic Phone Number: _____

Referring Provider's Signature_____

Referral Information

Referral Start Date _____ **End Date**_____ (up to 365 days)
AND Visits/Units _____

1. **Referred To Provider or Group**: _____

   Provider Billing NPI #: _____Phone Number_____

   Address: _____

Referral Approval Reason – choose one

- ☐ Assume Care
- ☐ Consultation/Diagnosis Only
- ☐ Diagnose & Treat
- ☐ Diagnose & Treat to include surgery
- ☐ Diagnosis, treat & forward to specialty provider(s) for this condition
- ☐ Hospital Admission
- ☐ One-time visit until seen by PCP
- ☐ Follow patient jointly

☐ DME* ☐ Mental Health Services* ☐ Developmental Disability Services* ☐ Other-describe*

If the reason selected has an (*), specific services included in this referral must be documented below

NOTES:_____

_____

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If you have questions regarding this referral, please contact: _____

Updated 11/28/2012