Maryland Uniform Consultation Referral Form

Date of Referral:	**Carrier Information:**
Patient Information:	Name:
Name: (Last, First, MI)	Address:
Date of Birth: (MM/DD/YY) — Phone: ( )	Phone Number: ( )
Member #:	Facsimile/Data #: ( )
Site #:	

Primary or Requesting Provider:

Name: (Last, First, MI) Mbonu, Ikechukwu		Specialty: Internal Medicine
Institution/Group Name: Paraclete Care Inc.	Provider ID #: 1 1841291788	Provider ID #: 2 (If Required)
Address: (Street #, City, State, Zip) 810801 HICKORY RIDGE RD STE 215 COLUMBIA, MD 21044-3871		
Phone Number: ( ) 410-740-4411	Facsimile/Data Number: ( ) 410- 740-4421	

Consultant/Facility Provider:

Name: (Last, First, MI) **Evangelista, Nina**		Specialty: Physical Therapy
Institution/Group Name: **AAA Physical Therapy, LLC**	Provider ID #: 1 **142.730.4948**	Provider ID #: 2 (If Required)
Address: (Street #, City, State, Zip) 6955 Oakland Mills Rd Ste E Columbia, MD 21045		
Phone Number: ( ) **443.979.7171**	Facsimile/Data Number: ( ) **667.200.5908**	

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)

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.

White: Carrier; Yellow: Primary or Requesting Provider; Pink: Consultant/Facility Provider; Goldenrod: Patient

See Carrier/Plan Manual for Specific Instructions.