

Insurance

Maryland Uniform Consultation Referral Form

Date of Referral:	Carrier Information	
Patient Information:		
Name: (Last, First, MI)		Name: Aetna
Date of Birth: (MM/DD/YY)	Telephone Number: ()	Address: PO Box 981288 El Paso, TX 79998-1288
Member #:		Phone Number: (888) 632-3862
Site #:		Facsimile/Data #: (800) 588-2386

Primary or Requesting Provider:

Name: (Last, First, MI)	Specialty:	
Institution/Group Name:	Provider ID #: 1	Provider ID #: 2 (If Required)
Address: (Street Number, City, State, ZIP Code)		
Telephone 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 Number, City, State, ZIP Code)		
Telephone Number: ()	Facsimile/Data Number: ()	

Referral Information

Reason for Referral:	
Brief History, Diagnosis and Test Results:	
Services Desired: Provide Care as Indicated: <input type="checkbox"/> Initial Consultation Only <input type="checkbox"/> Diagnostic Test (Specify): _____ <input type="checkbox"/> Consultation with Specific Procedures (Specify): _____ <hr/> <input type="checkbox"/> Specific Treatment: _____ <input type="checkbox"/> Global OB Care & Delivery <input type="checkbox"/> Other (Explain): _____ <hr/>	Place of Service <input type="checkbox"/> Office <input type="checkbox"/> Outpatient Medical/Surgical Center * <input type="checkbox"/> Radiology <input type="checkbox"/> Laboratory <input type="checkbox"/> Inpatient Hospital * <input type="checkbox"/> Extended Care Facility * <input type="checkbox"/> Other (Explain): _____ <hr/> * Specific Facility Must be Named
Number of Visits: _____ If Blank, 1 Visit is Assumed	Authorization Number: _____ (If Required)
Signature (Individual Completing this Form)	
Referral is Valid Until: (Date) _____ (See Carrier Instructions)	
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.

See Carrier/Plan Manual for Specific Instructions.