Maryland Uniform Consultation Referral Form

Date of Referral:	Carrier Information: Name: Kaiser Permanente Address: Phone Number: 1-(800)-810-4766 option 2 Facsimile/Data #: 1-(800)-660-2019
Patient Information:	
Name: (Last First, MI)	
Date of Birth: (MM/DD/YY) / Phone: ( )	
Member #:	
Site #:	

Primary or Requesting Provider:

Name: (Last, First, MI)	Specialty:	
Institution/Group:	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:	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, Test Results:	
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 Instruction)
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.