CONNECTIONS Referral Form

Please use this form to refer a Buckeye Community Health Plan member for a visit from a Buckeye CONNECTIONS Representative.

Date:____________

Member Name:____

MMIS ID #:____

Member Address:____

Member Phone #: ____

Provider Fax# & Contact Name:___________________________________

Please check the reason for the referral:

☐ **Non Compliance**

☐ **Missed appointments (minimum of three missed)**

☐ **High emergency room usage**

☐ **Other (explain):____**

Please use the space below to give details about the referral and your expectation of the CONNECTIONS visit:

Provider Name: ____
Provider phone number:____
Requested By: ________________________________Ext________________
Date Completed _____________________ Phone Log# _________________

Please fax this form to:
Michael Craun: 866-353-8315

Rev: 08-13-09