CONNECTIONS Referral Form

Please use this form to refer a Buckeye 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