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Community Health Service Department Referral Form

Please use this form to refer a Buckeye Health Plan member for a visit from a Buckeye CHSD.

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**

☐ **Coaching: Readmission, Diabetic, Asthma:_____**

☐ **Other (explain): _____**

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

Provider Name: _____
Provider phone number: _____
Requested By:_____
Date Completed _____

Please fax this form to:
***Kim White or Monique Guerrero:* 866-528-9924**

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