

**Team Care Program Referral Form**

**To make a referral to Team Care, please complete the following information and fax it to (855) 275-1212.**

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| **VT Medicaid (Patient) Information** |
| Name: Click to enter. | DOB:Click to enter. |
| Address:Click to enter. | City:Enter | State:Enter | Zip:Enter |
| Telephone:Click to enter. | Medicaid ID:Click to enter. |

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| **Your Information** |
| Date of submission:Enter date. | Click to enter a date. |
| Address:Click to enter. | City:Click to enter. | State:Enter text. | Zip:Enter. |
| Email:Click to enter. | Telephone:Click to enter. |
| Are you a Medicaid provider?[ ] Yes [ ] No | Provider ID if applicable:Click to enter. |
| Other (please explain):Click to enter. | Is patient aware of referral? [ ] Yes [ ]  No |

**Reason for Referral**

*Please list as much detail as possible and include copies of any documents that may support referral*

Click to enter text.

Please Note: referrals to Team Care are reviewed through an established protocol and must meet eligibility criteria for enrollment. Due to privacy concerns, notices of the determination are not automatically generated.

**Please call (802) 238-6039 with any questions.**

Team Care Use Only - Date Rec’d: \_\_