

***Team Care Program Referral Form***

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

|  |
| --- |
| **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. |

|  |
| --- |
| **Your Information** |
| Name:Click to enter. | Date of submission:Enter 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 for any questions.

Team Care Use Only:

Date Rec’d:

Determination:

Date: