

**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: \_\_