R10/16

***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:  | DOB: |
| Address: | City: | State: | Zip: |
| Telephone: | Medicaid ID: |

|  |
| --- |
| **Your Information** |
| Name: | Date of submission: |
| Address: | City: | State: | Zip: |
| Email: | Telephone: |
| Are you a Medicaid provider?[ ] Yes [ ] No | Provider ID if applicable: |
| Other (please explain): | 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*

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: