MemberConnections® Member Referral Form

Fax this completed form to: 1-866-518-6035

Complete this form to refer a Managed Health Services (MHS) member for education regarding one of the three options listed on this form. MHS will outreach to the member within 10 business days of receiving your request. *For more information on removing a member from your panel, please review the MHS Provider Manual, available at mhsindiana.com/providers/resources, or contact MHS Provider Services at 1-877-647-4848.*

Member Name:			
Member ID #:			DOB:
Member Parent/Guardian Name (if applicable):			
Member Address:			
City:	State:	Zip:	Member Phone #:

Provider Name/Practice Name:		
Provider Office Contact Name:		
Fax #:	Phone #:	Referral Date:

Please check the reason for the referral & indicate date(s) of service (if applicable):

☐ Missed at least 3 appointments:_____

☐ Inappropriate use of the emergency room: _____

☐ Please send member info on available community resources (food pantries, WIC, shelters, etc.)

Please provide any further explanation or special instructions needed for the referral: _____

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