Montana Medicaid/HMK *Plus*
Passport to Health Referral

Passport Provider's Name & Phone_____

Patient's Name:_____

Patient's Member Number: _____

Date of Birth: _____

Name of provider referred to: _____

Specialty:_____Phone Number: _____

Diagnosis/problem: _____

Services Requested:

(Please check all that apply)

- ☐ Evaluate and recommend treatment (1 visit)
- ☐ Initiate treatment and refer back to me (2-3 visits)
- ☐ Continued Supervision (Circle number of visits: 4 5 6)
- ☐ Specific Procedures _____
- ☐ Surgery (Please Specify)_____
- ☐ Other_____

Length of Referral:

☐15 Days ☐30 Days ☐_____

Please attach pages if necessary for the following

Limitations (Please Specify): _____

Follow-up Instructions: _____

Remarks: _____

PASSPORT PROVIDER SIGNATURE **PASSPORT REFERRAL #** **DATE REFERRAL AUTHORIZED**

NOTE TO REFERRED-TO PROVIDER: IN ALL CASES, PLEASE COMMUNICATE YOUR ASSESSMENT AND RECOMMENDATION BACK TO THE PASSPORT PROVIDER. IF SERVICES BEYOND THOSE AUTHORIZED ARE NEEDED, CALL PASSPORT PROVIDER FOR ADDITIONAL AUTHORIZATION. RETAIN THIS FORM IN THE MEMBER'S FILE.