



# Member Connections® Referral Form

Please use this form to refer a Louisiana Healthcare Connections member for a follow-up by one of our **Member Connections** representatives.

Date (please print) \_\_\_\_\_

Member Name \_\_\_\_\_

MMIS ID # \_\_\_\_\_

Member Address \_\_\_\_\_

Member Phone \_\_\_\_\_

Provider Contact \_\_\_\_\_

Provider Fax \_\_\_\_\_

**Please check the reason for referral:**

- Non-Compliance: with Treatment Plan
- Non-Compliance: with Medication Adherence
- Inappropriate Conduct in the Treatment Setting
- Missed Appointments (minimum of 3)
- High Emergency Room Usage (3 or more visits)

**Details of the reason for the referral, and your expectations of the Member Connections follow-up:**

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\_\_\_\_\_

Provider Name \_\_\_\_\_

Provider Phone \_\_\_\_\_

**Please fax this completed form to Member Connections at: 1-877-644-4544**