District of Columbia Medicaid Referral Form

PATIENT CONTACT INFORMATION

Patient Name: _____

Date of Birth: _____/_____/_____ **Patient Age (for child under 3 in months):** _____ **Gender:** M F

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Parent /Guardian Name: _____ **Relationship to Patient:** _____

Primary Language: _____ **Home Phone:** _____ **Other Phone:** _____

E-mail: _____

INSURANCE: _____ **INSURANCE ID#:** _____

REASONS FOR REFERRAL

Reason for referral (including all relevant clinical information): _____

_____

_____

ICD-9/CPT CODES:

X	SPECIALTY	# visits	X	SPECIALTY	# visits
	Allergy			Neurosurgery	
	Cardiology			Nuclear Medicine	
	Cardiovascular Surgery			Nutrition	
	Dermatology			Occupational Therapy	
	Developmental Pediatrics			Ophthalmology	
	Early Intervention (ITDD) (fill out the back of the form)			Oral Surgery	
	Endocrinology			Orthopedic Surgery	
	Gastroenterology			Otolaryngology	
	General Surgery			Physical Medicine & Rehab	
	Genetics			Physical Therapy	
	Gynecology			Plastic Surgery	
	Hearing/Audiology			Psychiatry	
	Hematology and Oncology			Psychology	
	HIV/AIDs Specialist			Pulmonary	
	Immunology			Radiology	
	Infectious Disease			Rheumatology	
	Mental and Behavior Health			Speech Therapy	
	Neonatology			Substance Abuse	
	Nephrology			Urology	
	Neurology			Other (specify)	

REFERRAL SOURCE CONTACT INFORMATION

Referring Provider: _____ **Date of Referral:** _____/_____/_____

Address: _____

Office Phone: _____/_____-_____ **Office Fax:** _____/_____-_____ **E-mail:** _____

Signature: _____ **Date:** _____

Fill out the authorization information below or attach a print out of a referral verification

Provided by Plan/Carrier: **DATE APPROVED:** **DATE SPAN:** **REFERENCE #:**

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan/carrier.

See Carrier/Plan Manual for Specific Instructions

Early Intervention Disclosure Form

Please fax this form to the Infants and Toddlers with Disabilities Division (ITDD) at 202-724-7230

If you have any questions, please call 202-727-5785

I authorize, as the **parent** or **legal guardian** of _____(child's name), a developmental screening and/or a multidisciplinary evaluation to be completed for my child, which will assess my child's development in the following areas:

- **Cognitive development** (thinking and learning skills)
- **Physical development** (moving, running, crawling, use of hands)
- **Communication development** (understanding and using sounds, gestures and words)
- **Social-Emotional development** (responding to and developing relationships with others)
- **Adaptive development** (taking care of one's self when doing things like feeding and dressing)
- **Sensory development** (hearing, seeing)

I also authorize_____to release the following information (check all that applies):

Referral Information	Physical Therapy Evaluations	Developmental Evaluation or Screening Results	Other:_____
Admission Summary	Occupational Therapy Evaluations	Hearing Screen or Test Results	Other:_____
Discharge Summary	Speech Therapy Evaluations	Vision Screen or Test Results	Other:_____

… to the following agencies and programs, and for the following reasons:

Early Intervention Program at the DC Department of Human Services in order to establish my child's eligibility for early intervention services.

For children who are 2 years, 6 months or older– DCPS responsible for my child in order to establish my child's eligibility for special education preschool services at three years of age.

I understand that once released, my information may be disclosed and may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA), but will not be re-disclosed by the DCPS, in accordance with the Family Educational Rights and Privacy Act (FERPA).

For more information, see 45 CFR (Code of Federal Regulations) 164.508 for HIPAA and 34 CFR Part 99 for FERPA.

I understand that signing this authorization is not a condition of receiving future medical treatment or early intervention services.

I understand that I may revoke (i.e., cancel) this authorization at any time by notifying the Early Intervention Program or DCPS in writing, and that any information shared prior to revoking this authorization will not be affected by a revocation.

I understand that before any specific services for my child are provided, I also have the right to prior authorize or decline those services.

This authorization expires_____(expiration date or event).

Signed:_____ Date:_____ copy to parent or legal guardian
(child's parent or legal guardian)

Signed:_____ Date:_____
(referring provider)