PRIMARY CARE CASE MANAGEMENT (PCCM) PROGRAM REFERRAL

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 708 (Rev 3-2016)

Clear Fields

NOTE:THIS FORM IS FOR PCP REFERRALS ONLY! *AN INCORRECT FORM MAY DELAY THE AUTHORIZATION PROCESS*
FOR OUT-OF STATE REFERRALS REQUEST: USE SFN 769.
FOR COORDINATED SERVICES PROGRAM (CSP) REFERRALS: USE SFN 231

Recipient's Name	Date Of Birth	Medicaid Number

REFERED TO CONSULTING PROVIDER/FACILITY

Referred to Consulting Provider/Facility Name	Referral Dates Effective thru

Diagnosis/Reason for Referral

This notice authorizes the following care:

- ☐ Evaluation only
- ☐ Evaluation and treatment
- ☐ Evaluation and single treatment
- ☐ As needed
- ☐ Other (specify below)

Number of treatments (if applicable)

Additional Referral Information

REFERRING PHYSICIAN INFORMATION

Referring Provider's Name (Please print)	Referring Provider's NPI
Referring Provider's Signature	Date

- Keep this form in the recipient's record; send a copy to the state office **only if** requested for auditing purposes.
- It is the consulting provider's responsibility to verify eligibility prior to delivering services.
- The Department's policy is that referrals be effective for no more than one year from the date of issue.
- All evaluations require a written or electronic report to the Primary Care Provider.
- Further information regarding PCCM referrals can be located within the General Information for Providers Manual at http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/gen-info-providers.pdf