

CONNECTICUT RIVER VALLEY FARMWORKER HEALTH PROGRAM 2012 REFERRAL VOUCHER

Is this referral urgent?

Yes No

NUMBER: 12-

SECTION I: Patient Information

Cell phone number (mandatory): (____) _____ - _____

Patient Name - Last

First

Middle

____/____/____
DOB (month/day/year)

Address

Town

State

Zip Code

SECTION II: Referred TO Information

Health Center/Health Care Facility patient is being referred to: _____

Reason(s) for appointment/referral: _____

Type of care needed: Medical Dental Optometry, CPT: _____ ICD-9: _____
 Lab X-ray Ophthalmology, CPT: _____ ICD-9: _____
 Mental health/Substance abuse Specialty care, specify: _____

Date referral appointment is made for: _____

SECTION III: Referred BY information

AUTHORIZATION: I hereby authorize disclosure of Protected Health Information (PHI) and the subsequent release of records to the Massachusetts League of Community Health Centers, CRVFHP, its funding source, and to the referred / referring Health Provider; the purpose of this authorization is to support and document medical care and / or process payments to migrant and seasonal farmworkers and their dependents which are supported directly and indirectly through CRVFHP Medical Care and / or Enabling/Outreach funds in 2012.

Patient (or Parent / Guardian) Signature: _____ Date of Referral: ____/____/____

Health Care Provider (sign): _____ (print): _____

Agency / Provider: _____ Date of Referral: ____/____/____

CONNECTICUT RIVER VALLEY FARMWORKER HEALTH PROGRAM

2012 REFERRAL VOUCHER

Referral Voucher Process for UConn:

If UConn deems it necessary to refer an eligible MSFW to a Participating Health Care Provider for medical care services outside their scope of practice, it must:

- Submit a completed CRVFHP Referral Voucher Form to the League (once per visit; white copy), and
- Submit a completed CRVFHP Referral Voucher Form to the Participating Health Care Provider (once per visit; yellow copy).

Referral Voucher Process for Participating Health Care Provider:

If a Participating Health Care Provider deems it necessary to refer an eligible MSFW to an External Referral Provider for specialty care services outside their scope of practice, it must:

- Submit a completed CRVFHP Referral Voucher Form to the League (once per visit; white copy),
- Have a written agreement in place with the External Referral Provider covering the services to which it refers MSFWs/dependents,
- Agree to accept claims from the External Referral Provider for referred, covered specialty care services,
- Agree to reimburse the External Referral Provider on a fee-for-service basis at a rate not to exceed the External Referral Provider's Medicaid Program rate for medical, dental and / or mental health services, and
- Review these claims for accuracy, completeness and appropriateness before applying to the CRVFHP for payment.

Claims for non-covered services will not be processed or paid.

Instructions for completing the Referral Voucher:

1. **If UConn**, UConn completes all sections of form retaining pink copy and submits yellow copy to Participating Health Care Provider.

or

If Participating Health Care Provider, Participating Health Care Provider completes all sections of form retaining yellow copy and Outreach staff retain pink copy for their records/reference.

2. **Please note:** If a Participating Health Care Provider is making a referral outside the health center, the name of the referral agency must be listed in Section II. You must clearly identify documentation related to reimbursement for referred services with the Date of Service and numbered CRVFHP Referral Voucher that substantiates the medical care visit and referral.
3. The white copy (and annual CRVFHP Eligibility/Registration Form) is forwarded to:

Massachusetts League of Community Health Centers
Attention: CRVFHP
40 Court Street, 10th Floor
Boston, MA 02108