Department of Human Services
HealthWorks
P.O. Box 709
Augusta, ME 04332-0709
1-800-977-6740
or (207) 621-2300
Fax # : (207) 621-2332
Medicaid Voice Response: 800-452-4694
Medicaid Inquiry: 800-321-5557

State of Maine

Maine PrimeCare Referral Form

FAXED 8/18/00

(Type or print clearly all information/multiple copies)

1. PATIENT INFORMATION: KASSidy (First Name) Bortner (Last Name)

Medicaid ID# 67216061A (Use Medicaid # only)

Date of Birth 2-4-99 (MM/DD/YYYY)

2. REFERRAL TO:

Name James Timoney

Address 2 Great FAlls PlAzA Auburn, Me

Telephone # 783-1328 ~~783-9000~~ 795-1397

Appointment Date/Time 9-11-00 (MM/DD/YYYY 00:00AM/PM)

3. TYPE OF REFERRAL: (Check all that apply)

- [ ] Single consultation visit for opinion
- [x] Treatment up to 3 visits (If not specified, three visits will be authorized)
- [ ] No diagnostic procedures
- [ ] Single visit for treatment
- [ ] No lab, x-ray
- [x] Valid for 6 months (If not specified, this referral will be valid for six months)
- [ ] Surgery/Admit
- [ ] Therapy: OT ___ PT ___ SP ___
- [x] Other, please explain in box #4.

4. CLINICAL INFORMATION:

Reason for referral

Toeing in

5. REFERRAL AUTHORIZATION: (Authorization # must match PCP/PCPS of record. Authorized signature may be PCP or designated personnel at site)

Primary Care Provider/Site (Name) PediAtric Associates

Authorized Signature George Glass

Authorization Number 00020f0007 (HCFA1500=Block 17a/UB92=Block 11)

Date 8-16-00 (MM/DD/YY)

*This referral is not a guarantee:

A. That the service is a covered Medicaid service;

B. That the patient will be eligible for Medicaid at the time of service; or

C. That the service has received Prior Authorization from the Department. Prior Authorization is required for certain surgical procedures, durable medical equipment (DME) and all out-of-state services - 800-321-5557 ext 72033.

WHITE - HealthWorks **YELLOW** - Referral Provider **PINK** - PCP/PCPS **GOLD** - Patient

Pediatric Associates of Lewiston
REFERRAL FORM

783-1328 Date: 8 - 06

Name: Kass'idy Bartner

D.O.B: 2-4-99

Referral To: Ortho

Diagnosis: Toeing in

Patient needs to be seen within:
Stat:(same day)____
ASAP: (within 1-2 weeks)________
Whenever Available:________
Prefers:________

Consulting Physicain________

Timoney Mon Sept 11 @ 3:15