

Elderplan Referral Request Form

Fill out this form to request a referral for your patient to see a specialist. Please make sure you email the form to **FBHSpecialistReferrals@mjhs.org** at least 14 calendars days in advance of the appointment¹, since processing can take that long.

** Required field*

Member Information	
* Date of referral request:	
* Full name:	
* Date of birth:	
* Elderplan member ID #:	
Primary Care Provider Information	
* Full name:	Fax #:
* NPI #:	
* Contact phone #:	Email:
Office address:	
Additional Information	
* Specialist name:	* Number of visits requested:
Specialist's NPI #:	
* Provider specialty:	* Date span requested (MM/DD/YYYY): _____ to _____
* Specialist's address:	Diagnosis(es) with ICD-10 codes:
* Specialist's contact phone #:	Specialist's fax #:
Specialist's email:	
Reason(s) for visit:	
* Is this is a referral to an ambulatory surgical center? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional comments:	

¹ Referral request form must be submitted within 30 calendar days of primary care provider visit.