AmeriHealth Caritas Florida

Referral Form

Member information

Member number:	Member last name:	Member first name:
Date of birth:	Member phone number:	Gender: ☐ Male ☐ Female

Provider information

Primary care provider name:	PCP number:	County:
Phone:	Fax:	

Specialist information

County:	Type (specialty):	Specialist provider name:
Provider phone:	Provider address::	
Diagnosis (ICD-10):		

☐ Evaluation only	Evaluation plus visit #	Time frame: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 1 year

Background description

Service requested and reason for referral