

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General & Secretary

Vision: To be the Healthiest State in the Nation

REFERRAL FORM

Please type or print legibly

CLIENT AND FAMILY INFORMATION

Client's Name:		Date of Birth:	Social Security Number:	Medicaid Number:
Parent/Guardian Name:				Date of Birth:
Telephone Number:	Mailing Address:			

Referred to:	Specialty:
Address:	

From (name of person making referral) PLEASE PRINT:	Title:	Telephone Number:
Agency:	Fax Number:	
Address:		

Reason for Referral/Notes to Referral Agency:

LIST SERVICES AUTHORIZED

Rate Authorized:

Applicable Medicaid Rate Up to _____ dollars

Per Contract No Payment Authorized

If on Medipass of HMO, indicate authorization number

Medipass / HMO #: _____

Expiration Date: _____

	Referring Person's Signature	Date
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Response to Referral Originator:

	Referring Person's Signature	Date
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