MHS
Real Life Solutions for Health Care
Managed Health Services

MANAGED HEALTH SERVICES
REFERRAL AUTHORIZATION REQUEST FORM

PMP Name	Member Name	MBR DOB	RID/Member Number	DX Code	Specialist, Covering Phys. or Nurse Practioner's Last name	Specialist, Covering Phys. or Nurse Practioner's First name	Type of Specialty	# of Visits	If Preg EDC	Appt Date	MHS Auth Number

Office Contact Name: _____

Office Phone Number: _____

Office Fax Number: _____

Fax To: MHS Medical Management Department
Attn: Referrals
1-866-912-4245 Fax
(877)MHS-4U4U Phone

Please note that you will receive a response to your request within one (1) business day of receipt of this request at MHS.

MHS CONFIDENTIALITY NOTE

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