Team Care Provider Referral Fax Form

Montana DPHHS
Managed Care Bureau
Fax to: (406) 444-1861
Phone: (406) 444-1518

Provider: _______________
NPI: _______________
Phone: _______________
Fax: _______________

Please provide the following patient data when making referrals into the Team Care Program.

1) Patient name: ____________________
Medicaid ID #: ____________________
Date of Birth: ____________________

Reason for referral:
____
____
____

2) Patient name: ____________________
Medicaid ID #: ____________________
Date of Birth: ____________________

Reason for referral:
____
____
____

3) Patient name: ____________________
Medicaid ID #: ____________________
Date of Birth: ____________________

Reason for referral:
____
____
____

Signed: ________________________ Date: ___________________________

Thank you! Your involvement is crucial for the creation of a successful program, and enables us to better focus our client education efforts.

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