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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