Member Connections® Referral Form

Please use this form to refer a Louisiana Healthcare Connections member for a follow-up by one of our **Member Connections** representatives.

Date (please print) _____

Member Name _____

MMIS ID # _____

Member Address _____

Member Phone _____

Provider Contact _____

Provider Fax _____

Please check the reason for referral:

- ☐ Non-Compliance: with Treatment Plan
- ☐ Non-Compliance: with Medication Adherence
- ☐ Inappropriate Conduct in the Treatment Setting
- ☐ Missed Appointments (minimum of 3)
- ☐ High Emergency Room Usage (3 or more visits)

Details of the reason for the referral, and your expectations of the Member Connections follow-up:

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_____

_____

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_____

Provider Name _____

Provider Phone _____

Please fax this completed form to **Member Connections** at: **1-877-644-4544**