mercy care

EXCLUSIVE PRESCRIBER PROGRAM REFERRAL FORM

INDIVIDUAL SENDING REFERRAL

Referred by:	
Contact E-mail:	
Referral Date:	

MEMBER INFORMATION

Member Name:		Date of Birth:	
Member ID: (A#)			

BEHAVIORAL HEALTH CLINIC INFORMATION

Clinic Name:			
Address:			
Treating Prescriber:		Phone:	
Prescriber’s E-Mail:		Fax:	

PCP INFORMATION

PCP Name:			
Address:			
Phone:		Fax:	
Other Involved Medical Prescriber:			
Address:			
Phone:		Fax	

BEHAVIORAL HEALTH & MEDICAL INFORMATION

Behavioral Health Diagnoses:	
Medical Diagnoses:	
All prescribed medications:	
Number of suicide attempts or overdose with controlled substance in the last 6 months:	

REASON FOR REFERRAL

To make a referral, please e-mail the completed form to: MCP-PharmLock2@AETNA.com