(800) 564-5465

mercy care

SPECIALIST REFERRAL FORM

Patient Information Date: _____

Member AHCCCS ID: _____ DOB: _____

Patient Name: _____

Patient Address: _____

Patient Phone: _____ Work Phone: _____

Primary Diagnosis: _____

Reason for Referral: _____

Requesting Primary Care (PCP) Information

PCP Name: _____

PCP Location: _____

PCP Phone: _____ PCP Fax: _____

Specialist Information

Specialist Name: _____ Specialty: _____

Specialist Address: _____

Specialist Phone: _____

Number of specialist visits requested by PCP: _____

PCP Signature: _____