MERITAIN HEALTH

Piscataway Township
Referral Request Form

From

Clinic _____ Contact Name _____

Fax Number _____ Contact Number _____

Member

Employee Name _____ Employee ID # _____

Patient Name _____ Pt Date of Birth _____

Primary Care Provider Information

Referring Provider Name _____

Referring Provider TIN (required) _____

Referral Reason _____

ICD 10 Code(s) _____

Procedure Code(s) _____

Start Date _____ Stop Date _____ (cannot be more than 1 year from start date)

Visits _____ (1-99 – if unlimited enter 99)

Comments _____

_____

_____

_____

Referred to Provider Information

Referred to Provider Name _____

Specialty _____ Location _____

Place Treatment will be rendered (office, OP, etc) _____

Referred to Provider TIN (required) _____ Referral Date _____

Submit the completed referral request form to Meritain Health, Inc.

NOTE: Do not send referral request with the claim. Referrals should be sent to Meritain prior to claim submission.

Email to FaxAEIReception@meritain.com
Fax to 602-789-9369

To verify eligibility and benefit limits call (800) 925-2272