CONNECTICUT RIVER VALLEY FARMWORKER HEALTH PROGRAM
2017 REFERRAL VOUCHER

Is this referral urgent? **NUMBER: 17-**

☐ **Yes** ☐ **No**

SECTION I: Patient Information

Cell phone number (mandatory): (____) _____-_________
Is this a pre-paid or shared phone? Yes _____ No _____
If yes, provide an alternate number: (____) _____-_______

____________________________ ________________________ ____________________ _____/_____/________
Patient Name - Last First Middle DOB (month/day/year)

____ ___________________________ ______ ________________
Address Town State Zip Code

SECTION II: Referred *TO* Information

Health Center/Health Care Facility patient is being referred to: ____

Reason(s) for appointment/referral: ____

Type of care needed:
☐ Medical ☐ Dental* ☐ Optometry, CPT: ____________ ICD: _______________
☐ Lab ☐ X-ray ☐ Ophthalmology, CPT: ____________ ICD: ___________
☐ Mental health/Substance abuse ☐ Specialty care, specify: __________________________

** Does not include dentures or implants*

Date referral appointment is made for: ________________________

SECTION III: Referred *BY* information

AUTHORIZATION: I hereby authorize disclosure of Protected Health Information (PHI) and the subsequent release of records to the Massachusetts League of Community Health Centers, CRVFHP, its funding source, and to the referred / referring Health Provider; the purpose of this authorization is to support and document medical care and / or process payments to migrant and seasonal agricultural workers and their dependents (MSAWs) which are supported directly and indirectly through CRVFHP Medical Care and / or Enabling/Outreach funds in 2017.

Patient (or Parent / Guardian) Signature: ____________________________________ Date of Referral: ______/______/_______

Health Care Provider (sign): ____________________________________ (print): ______________________________________

Agency / Provider: ____ Date of Referral: ______/______/_______

White Copy – CRVFHP (mail) **Yellow Copy – Agency / Provider** **Pink Copy – UConn / Outreach** **Gold Copy - Patient**

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Referral Voucher Process *for UConn*:

If UConn deems it necessary to refer an eligible MSAW to a Participating Provider for medical care services outside their scope of practice, it must:

- Submit a completed CRVFHP Referral Voucher Form to the League (once per visit; white copy), and
- Submit a completed CRVFHP Referral Voucher Form to the Participating Provider (once per visit; yellow copy).

Referral Voucher Process *for Participating Providers*:

If a Participating Provider deems it necessary to refer an eligible MSAW to an External Referral Provider for specialty care services outside their scope of practice, it must:

- Submit a completed CRVFHP Referral Voucher Form to the League (once per visit; white copy),
- Have a written agreement in place with the External Referral Provider covering the services to which it refers MSAWs/dependents,
- Agree to accept claims from the External Referral Provider for referred, covered specialty care services,
- Agree to reimburse the External Referral Provider on a fee-for-service basis at a rate that does not exceed the External Referral Provider's Medicaid Program rate for medical, dental and / or mental health services, and
- Review these claims for accuracy, completeness and appropriateness before applying to the CRVFHP for payment.

Claims for non-covered services will not be processed or paid.

Instructions for completing the Referral Voucher:

1. ***If UConn***, UConn completes all sections of form retaining pink copy and submitting the yellow copy to Participating Provider.

   or

   If Participating Provider, Participating Provider completes all sections of form retaining yellow copy and Outreach staff retain pink copy for their records/reference.

2. Please note: If a Participating Provider is making a referral outside the health center, the name of the referral agency must be listed in Section II. You must clearly identify documentation related to reimbursement for referred services with the Date of Service and numbered CRVFHP Referral Voucher that substantiates the medical care visit and referral.

3. The white copy (and annual CRVFHP Eligibility/Registration Form) is sent via encrypted email or mail to:

   Massachusetts League of Community Health Centers
   Attention: CRVFHP
   40 Court Street, 10th Floor
   Boston, MA 02108

- **ALL PATIENT-IDENTIFIABLE DOCUMENTATION MAILED TO THE CRVFHP MUST BE MARKED CONFIDENTIAL.**