



Kentucky Lock-In Provider Referral Form

Date of referral: _____

Primary Care Physician/Referring Physician: _____

Contact phone number: _____

Authorization

I allow _____ to provide only
Name of referred physician

Description of service (e.g., consultation, office visit, pain management, surgery)

to _____ Medicaid ID No. _____
Name of Medicaid lock-in enrollee

for symptoms and conditions of _____.

Authorized dates of service: _____ to _____

Signature of designated primary care physician/referring physician

Referred-to provider: Please contact my office at the phone number above to forward lab results, consultation information and/or to make recommendations for additional services that may be medically necessary (e.g., nonemergency diagnostic procedures, medical supplies, medications, surgical procedures).

Referring physician: Please submit a copy of this referral with your paper claim. Please keep one copy of this referral in the lock-in enrollee's file and send one copy to the referred-to provider. Upon request, provide one copy to the enrollee.

Questions relating to the Kentucky Lock-In Referral Form may be directed to Humana – CareSource® provider relations by calling 1-855-852-7005.

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