absolute total care™
Healthy Connections

MemberConnections
Referral Form

Use this form to refer an Absolute Total Care member for a visit from an Absolute Total Care Connections Representative.

Date: _____

Member Name: _____

MMIS ID #: _____

Member Address: _____

Member Phone #: _____

Provider Fax # & Contact Name: _____

Please check the reason for the referral:

☐ Non-Compliance
☐ Missed Appointments (minimum of three)
☐ High Emergency Room Usage
☐ Other (please explain):

Please give details as to the reason for the referral and your expectation of the MemberConnections visit:

_____
_____
_____
_____
_____
_____

Provider Name: _____

Provider Phone Number: _____

1441 Main Street • Columbia, SC 29201 • (866) 433-6041 • Fax (866) 912-3610