

Missed appointment referral form

This form is for the Health Promotions team to use when assisting providers with patients who have chronically missed appointments and who have violated the no-call, no-show appointment policy more than three times.

Today's date: _____ Existing patient New patient
 Member name: _____
 Medicaid ID: _____ Amerigroup member ID: _____
 Member address: _____
 City: _____ State: _____ ZIP code: _____
 Home phone: _____ Cell phone: _____

Please check the reason for the referral (mark all that apply):

____ Failure to keep three consecutive appointments
 ____ Failure to maintain Early and Periodic Screening, Diagnosis and Treatment standard(s)

Date	Reason for no-show*	Comments Please attach additional notes if more space is needed.
1st appointment:		
2nd appointment:		
3rd appointment:		

* Only applicable if office followed up with patient.

Provider information

Provider name: _____
 Medicaid ID: _____ Amerigroup provider ID: _____
 Provider address: _____
 City: _____ State: _____ ZIP code: _____
 Office contact name: _____ Phone: _____

Please fax this completed form to Amerigroup Health Promotions at 1-888-220-6712 or email to gahlthpro@amerigroup.com.

Important Note: You are not permitted to use or disclose Protected Health Information about individuals that you are not currently treating or have enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.