

**Kansas Lock-In Program: Provider Referral Form**

Date of referral: \_\_\_\_\_

This authorizes \_\_\_\_\_  
(Provider to whom the member is referred)

to only provide \_\_\_\_\_  
(Description of service)

to \_\_\_\_\_ Member ID: \_\_\_\_\_  
(Member name) (Medicaid or Amerigroup Kansas, Inc. ID number)

for symptoms and conditions of \_\_\_\_\_.

Referred physician may prescribe medications: Yes  No

Authorized date(s) of service: \_\_\_\_\_ to \_\_\_\_\_.  
(Specify if end date is open)

Please call my office at: \_\_\_\_\_ to forward lab results and consultation information or to make prescribing recommendations.

Lock-In primary care provider (PCP) signature: \_\_\_\_\_

Lock-In PCP national provider ID: \_\_\_\_\_

Date of signature: \_\_\_\_\_

**Assigned lock-In physician instructions:** Retain this referral in the member's medical record and forward a copy to the referred provider. The member should be provided a copy if prescribing privileges have been granted to the referred provider.

**Assigned lock-In pharmacy instructions:** Please verify prescription privileges are authorized when this referral is presented. The member is responsible for the cost of prescriptions if prescribing privileges have not been granted by the PCP to the prescribing provider.

Please fax or email a copy of the completed referral form to Amerigroup Lock-In Program:

- Fax: 1-877-820-9028
- Email: [KS\\_Lock-In\\_Program@Amerigroup.com](mailto:KS_Lock-In_Program@Amerigroup.com)

**Important note:** You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not 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.