WISEWOMAN Referral for Medical Evaluation

Client Name _____ Birth Date _____ MBCIS #_____

Referred to _____ Phone # _____ Fax #_____

Referred by _____ Phone #_____

Reason(s) for Referral: ❑ Elevated BLOOD PRESSURE_____ ❑ Elevated TOTAL CHOLESTEROL_____
❑ Elevated GLUCOSE_____ ❑ Undesirable HDL CHOLESTEROL_____

Client Medical Evaluation Appointment Date: _____/_____/_____

Notes to Provider:

_____

_____

_____

_____

_____ _____
Signature Date

TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Medical Evaluation _____/_____/_____ BP on Date of Evaluation _____/_____

Medical Evaluation RESULTS and PLAN OF CARE. (Include any medications prescribed or changes to medications.)

❑ Medication _____

_____

❑ Other treatment_____

_____

_____ _____
Signature of Health Care Provider Date

Check the box of the Office Visit **CPT Code** for which you plan to bill. Please check **ONE** box only. Diagnosis Codes (**ICD-10**) can be found online at www.MiWISEWOMAN.org						
New		❑ 99202	❑ 99203	❑ 99204	❑ 99386	
Established		❑ 99212	❑ 99213	❑ 99214	❑ 99396	

Providers must have a current Memorandum of Agreement (MOA) with the WISEWOMAN program for services to be paid with WISEWOMAN program funds. Patients may choose to see a non-participating provider; however, those services will be the responsibility of the patient and should not be billed to the WISEWOMAN program.

** Patient acknowledgement of fees for use of a non-WISEWOMAN provider: _____

RETURN REPORT BY FAX: _____ ATTENTION: _____