100 Center Point Circle
Columbia, SC 29210

MemberConnections
Referral Form

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

Date: _____

Member Name: _____

MMIS ID Number: _____

Member Address: _____

Member Phone Number: _____

Provider Fax Number and 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:_____