1441 Main Street
Suite 900
Columbia, SC 29201

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:____