Please note that this fax form is to be used by those Provider Groups that are <u>not</u> participating in the Provider Led CMR program. Provider Led participants have access to the P3 Link Application and are able to complete CMRs for their attributed eligible MTM members.

<u>DO NOT SUBMIT SAME DAY APPOINTMENTS USING THIS FORM</u>

MTM REFERRAL REQUEST FORM: FAX TO (833)-887-4676 or EMAIL TO MTM_Referrals@highmark.com

Date: _____ Referred by: _____ Callback Number:_____

Provider Name: _____ BSID & Practice Name:_____

Member Name ***(Last, First)***	Highmark ID Number ***(UMI)***	State Member Resides In	Best time to Reach Member *Date and Time Monday 01/14 – 10 am*	Best Phone # to reach Member *Add all numbers listed for the member*	Discussed with Member or Caregiver and date.* *Member on 1/14/21 or Caregiver** Jane Doe on 1/14/21*	Notes for the Pharmacists *Any relevant information needed for the call*

**** For members with cognitive impairment, a written authorization (ADHI or POA) must be on file within Highmark Systems for Highmark pharmacists to disclose medical information to someone other than the member.***

***** For all other members, a verbal consent can be provided during the scheduled appointment time to complete the CMR with someone other than the member.***