

**FOR ACO/MCO INTERNAL
USE ONLY**Date Received: Click here to
enter a date.Date the Referral was
Denied/Approved: Click here to
enter a date.

MASSHEALTH COMMUNITY PARTNERS PROGRAM REFERRAL INTAKE FORM

Please send this intake form to the specified central point of contact for CP program referrals at the member's ACO/MCO. If you are unsure of the member's ACO/MCO, please contact **MassHealth's Customer Service Center** at 800-841-2900 with the member. The member must be present when contacting the Customer Service Center on their behalf.

REFERRED MEMBER INFORMATION

Name <i>(Last, First, M.I.):</i> Click here to enter text.		☐ M ☐ F ☐ Non-Binary	DOB: Click here to enter a date.
MassHealth Identification Number (if known): Click here to enter text.	Member's address: Click here to enter text.		
Member's primary language: Click here to enter text.	Member's legal guardian name and phone number (if applicable): Click here to enter text.		
Member's ACO/MCO (if known): Click here to enter text.	Member's phone number: Click here to enter text.		
Member's primary care physician: Click here to enter text.	Member's primary care physician's phone number: Click here to enter text.		
Member's primary medical/behavioral health/LTSS-related diagnosis: Click here to enter text.			
Reason(s) for Referral: Click here to enter text.		Contact information for agencies currently involved in member's care: Click here to enter text.	

REFERRAL SOURCE INFORMATION

Referral Source's Name: Click here to enter text.
Referral Source's organization/agency: Click here to enter text.
Referral Source's phone number: Click here to enter text.
Signature of Referral Source: Click here to enter text.