Michigan Department of Community Health
Medical Services Administration

BENEFICIARY MONITORING
PRIMARY PROVIDER REFERRAL NOTIFICATION / REQUEST

- **Read ALL instructions on the reverse side**
- **See PA 431 and Non-discrimination information on the reverse side**

The beneficiary named below requires medical services in addition to those that I provide.
I am referring this beneficiary to you as discussed with you and the beneficiary.

SECTION 1 – Beneficiary Information:

Beneficiary Name (Last, First, Middle)			MIhealth ID Number
Street Address			Home Telephone Number
City	State	ZIP Code	Work or Other Telephone Number

SECTION 2 – Primary Care Provider Information:

Name of Provider			Primary Care Provider ID Number
Business Address			NPI Number
City	State	ZIP Code	Telephone Number

SECTION 3 – Referred Provider and Appointment Information:

Name of Provider			Date of First Appointment	Time of First Appointment : ☐ AM ☐ PM
Business Address / Location of Appointment			Telephone Number	
City	State	ZIP Code	Referred Provider Medicaid ID Number	NPI Number

SECTION 4 – Reason for Referral and Authorization:

Primary Care Provider Authorizing Signature	Date of Authorization

Instructions for form MSA-1302
Beneficiary Monitoring Primary Provider Referral Notification / Request

REFERRING PROVIDER INSTRUCTIONS:

- This form should be used ONLY for those beneficiaries that are restricted to a primary provider in the Beneficiary Monitoring Unit.
- Please type or clearly print all applicable information.
- **COPY DISTRIBUTION: (Make photocopies as needed)**

  ORIGINAL - Mail to MSA, Beneficiary Monitoring Unit

  PHOTOCOPY - Primary Provider File Copy

  PHOTOCOPY - Referred Medical Provider File Copy

- The primary provider must mail the original copy of this form to:

  BENEFICIARY MONITORING UNIT
  MEDICAL SERVICES ADMINISTRATION
  PO BOX 30479
  LANSING MI 48909-7979

BENEFICIARY INSTRUCTIONS:

- You are being referred to another medical provider.
- The name and address of that provider is shown in Section 3 on the front side of this form.
- Your appointment DATE and TIME are also shown in Section 3.
- You must keep this appointment or call this provider to make another appointment.

AUTHORITY: Title XIX of the Social Security Act

COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.