

[Please place this referral form information on your agency's letterhead.]

**NORTH DAKOTA MEDICAID  
Primary Care Provider (PCP) Program  
Referral Form**

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Patient: \_\_\_\_\_

This patient is being referred to: \_\_\_\_\_  
Specialty Physician and/or Facility

Date of scheduled referral service: \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_ or limited  
to \_\_\_\_\_ visits. (The length of the referral cannot exceed 12 months.)

Diagnosis and reason for referral: \_\_\_\_\_

\_\_\_\_\_

Referring Physician: \_\_\_\_\_  
Printed

Referring Physician: \_\_\_\_\_  
Signature

Date of Physician's Signature: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referring Physician's UPIN: \_\_\_\_\_