Packet revised: 7/12/11

Intake & Referral Form

Rare and Expensive Case Management

Questions - Call 1-800-565-8190

Fax (410) 333-5426

Mail or Fax To:

REM Intake Unit
Department of Health & Mental Hygiene (DHMH)
201 W. Preston Street, Room 210
Baltimore, Maryland 21201

Referral Source: _____ Address: _____	
Phone	Fax

DHMH USE ONLY	
CM Agency:	
Date Assigned:	☐ Incomplete ☐ Complete
Screener/Date	Date Received:
County	
Date File Complete:	☐ Approved ☐ Denied Decision Date:

PATIENT INFORMATION

Patient Name				MA #:
Address				Home Phone
Apt. #		DOB:		Work Phone
City	State	Zip	Sex: **M** ☐ **F** ☐	S S #:

MCO United HealthCare	Contact Person
	Phone

Patient Contact		Contact Phone	
Address		Relationship to Patient	
Apt. #	City	State	Zip Code

Referring Physician	**Signature:**	Date:
Name	Phone	
Specialty	License #	
PCP		
Name	Phone	
Specialty	License #	
Consulting Physician		
Name	Phone	
Specialty	License #	

REM Intake & Referral Form

Patient Name: _____ **DOB:** _____

CLINICAL INFORMATION			
Primary Diagnosis		**Secondary Diagnosis**	
ICD-9 Code		ICD-9 Code	
	1		1
	2		2
	3		3
	4		4

SUPPORTING INFORMATION (ATTACH COPIES)
History
Physical
Laboratory/Pathology
Radiology
Consultations
Comments

MD Signature	**Date**