Reset Form

Managed Care Referral Request Form for Minnesota Restricted Recipient Program (MRRP)

For members in the restricted recipient program only. **This form can be submitted electronically at** Forms – South Country Health Alliance (mnscha.org) **or faxed to 507-431-6329.**

Date	Member Name	DOB	Member ID

Primary Care Provider		
PCP Name	**PCP NPI**	
Clinic Name	**Clinic Phone**	**Clinic Fax**
Completed By		

Referral Information	
Clinic/Facility Name	**Clinic/Facility NPI**
Specialty	**Clinic/Facility Location (City/State)**
Clinic/Facility Phone	**Clinic/Facility Fax**
Referral Reason	**Diagnosis**
Start Date	**End Date**
☐ **Secondary Prescriber:** The primary care provider authorizes the provider to prescribe medication.	
Prescriber Name	**Prescriber NPI**

For any questions, please call the Restricted Recipient Program Manager at 507-431-6370.

This form is utilized for members in the Restricted Recipient Program which requires a member's primary care provider to submit a referral to South Country for all specialists. This form will be faxed by South Country to the specialist to serve as notification that the member is authorized to receive care from the specialist.