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. Upon reciept of a referral, South Country will enter an authorization and fax an authorization letter to the specialist.