



NC DMA Carolina ACCESS Referral Form



Recipient Information

DMA-0009 V1.0

Recipient ID #: _____
 Last Name: _____ First Name: _____
 Date of Birth: _____ Gender: _____

Referring Provider Information

Referring Provider's NPI #: _____
 Referring Provider's Name of Practice: _____
 Site Address: _____
 City: _____ State: _____ 9 Digit Zip Code: _____

Referred to Provider Information

8. Referred to Provider's NPI #: _____
 9. Referred to Provider Name of Practice: _____
 Site Address: _____
 City: _____ State: _____ 9 Digit Zip Code: _____

Referral Information

10. Referral Type: Evaluate Treat Evaluate and Treat
 11. Referral Start Date: _____
 12. Referral End Date: _____
 13. Number of visits: _____ Unlimited visits (unlimited visits with no end date)
 A Referral does not guarantee payment. Payment of claims is subject to compliance with DHHS guidelines and restrictions

Complete this form to request a Carolina ACCESS referral be processed by CSC.

Requestor's Name _____ Phone Number: _____ Ext _____

Referring Provider's Signature: _____ Date: _____

Fax this form to CSC at: (855) 710-1964