MMM OF FLORIDA
Medicare and Much More

PCP Specialty Referral Form

Referral Date: _____

Member Name: _____ **D.O.B:** _____ **Member ID:** _____

Diagnosis: _____

Reason for Referral:

_____

_____

Referring Provider: _____ **NPI:** _____ **Specialty:** _____

Phone: _____ **Fax:** _____

Servicing Provider: _____ **NPI:** _____ **Specialty:** _____

Phone: _____ **Fax:** _____

Please fax the completed form to **833-334-3383.**

5775 Blue Lagoon Drive • Suite 450
Miami, FL 33126
O: (888)722-7559
www.mmm-fl.com