Affinity Health Plan

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affinityplan.org

Restricted Recipient Program
Referral Form

Recommendation for evaluation due to potential overutilization.

Request Date: ----/----/----

Please complete the following:

Member Name:	Member ID Number:
Medicaid/CIN Number:	Date of Birth:
Member Address:	Telephone Number:
	Product: □ Medicaid □ FHP

Name and contact information of person referring:

_____

Reason(s) for evaluation request: _____

_____

_____

_____

Type(s) of limitations(s) being recommended: _____

_____

_____

_____

Please attach all supporting documents.

Suggested provider(s) member should be limited to for special care:

Provider Name	
Provider Address	
Provider Contact Information	
Provider NPI Number	

Please note Restricted Recipient Committee meetings are held once monthly.

Please send this to form to the Restricted Recipient Coordinator via Email: ageorge@affinityplan.org or Fax at 718-536-3383.