



# FAX COVER SHEET



**TO: THSteps Special Services Unit/MAXIMUS**

**PHONE: 1-877-847-8377**

**Fax #: (512) 533-3867**

**FROM:**

**TELEPHONE:** (  )  -

**FAX #:** (  )  -

**DATE:**

**TIME:**

**TOTAL PAGES INCLUDING COVER SHEET:**

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# THSTEPS MISSED APPOINTMENT REFERRAL FORM



FAX REFERRALS TO SPECIAL SERVICES UNIT/MAXIMUS  
PHONE #1 (877)847-8377; FAX#(512)533-3867

## PROVIDER INFORMATION

Provider/Clinic Name: _____		Provider Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Case Manager <input type="checkbox"/> Promotora <input type="checkbox"/> Other		Provider #: _____
Address: _____	City: _____	State: _____	Zip Code: _____	County: _____
Provider Phone #: _____	Provider Fax #: _____	Total Referrals Submitted: _____	Date Referred: _____	

## PATIENT/CLIENT REFERRAL INFORMATION

Child/Adolescent Name: _____		DOB: _____	Medicaid #: _____	Phone #: _____
Address: _____		City: _____	State: _____	Zip Code: _____
Parent or Legal Guardian: _____			Language Preference: _____	
Date, Time & Number of Missed Appts: _____				
<b>Instructions to Texas Health Steps:</b> <input type="checkbox"/> Rescheduling assistance requested <input type="checkbox"/> Schedule follow-up exam <input type="checkbox"/> Provide updated address (case management) <input type="checkbox"/> Other, see comments		<b>Nature of Missed Appt:</b> <input type="checkbox"/> THSteps Medical <input type="checkbox"/> THSteps Dental <input type="checkbox"/> Orthodontic <input type="checkbox"/> Sick Visit <input type="checkbox"/> Follow-up Visit <input type="checkbox"/> Case Management Visit <input type="checkbox"/> High Lead Level <input type="checkbox"/> Other, see comments		
Comments: _____				

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