One Care Program—Provider Referral Form

Enrollment in One Care is open to MassHealth Standard or MassHealth CommonHealth members who meet the following criteria:

- are between the ages of 21 and 64
- have Medicare Parts A and B
- qualify for Medicare Part D (drug coverage)
- do not have any private health insurance (like health insurance from a job)
- do not participate in a Home and Community-Based Services (HCBS) waiver
- live in an area covered by a One Care plan.

To refer a patient, please complete the following information:

Patient Name | Date of Birth | Language Spoken

Patient Address

Patient Telephone | MassHealth ID#

Other Contact | Relationship | Telephone | Language Spoken

Referral date | Referred by | Primary Care Clinician

Title of person making referral (check all that apply)

☐ Primary care physician ☐ Nurse practitioner ☐ Social worker ☐ Other: ____________________

☐ **Patient agrees to the release of the above information to Commonwealth Care Alliance® and would like a Commonwealth Care Alliance representative to contact the Patient to discuss its program. Provider will fax the completed form to (617) 830-0534, Attn. O & M, for Commonwealth Care Alliance staff use only.**