Print Reset

MASSHEALTH RESIDENCY PROGRAM INTEGRITY REFERRAL FORM

Provider Contact Information:

Provider Name: _____

Contact Name: _____ Telephone Number: _____

E-mail Address: _____

Patient Information:

Applicant/Member Name: _____

Date of Birth: _____MassHealth ID # (if applicable): _____

Is the patient currently on MassHealth? ☐ Yes ☐ No

If no, has the patient applied for MassHealth? ☐ Yes ☐ No

Where did patient complete the MassHealth application, if known?

_____

Did patient express intent to live in Massachusetts? ☐ Yes ☐ No

Why do you believe patient does not meet MassHealth residency requirement?

_____

_____

_____

_____

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Submit via e-mail to: integrityreferral@massmail.state.ma.us and attach copies of any supporting documentation.