

HCAV INTERNET REFERRAL FORM

Referral From: **Patient** **Physician** **Hospital** **Case Manager** **Other**

Source Company Name: _____ Phone: _____
Name of Caller: _____ Date: _____ Time: _____

Patient Info

New Patient Existing Patient Change

Patient's Name: _____ Sex M F DOB: _____

Address: _____ Phone: _____

City, State, Zip: _____ SSN: _____

Employer: _____ E-MAIL: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Is This Patient's Permanent Address: Y N Facility: Home Nursing Home
 Retir. Home Other _____

Physician Info

Info on File New Physician Date Last Seen: _____
 Other Ordering Attending Consulting

Name: _____ UPIN#: _____

Address: _____ Office Contact: _____

Phone: _____

City, State, Zip: _____ Fax #: _____

Equipment Needed DESCRIBE THE ITEMS NEEDED.

Description	Quantity
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Medical Info INCLUDE THE ICD-9 CODE AND DESCRIPTION IF KNOWN, IF NOT, GIVE REASON FOR NEED.

Estimated Length of Need: 6 Months 12 Months Lifetime Other: _____

Is patient in hospital? YES NO Facility/Rm # _____

Discharge date _____ Height: _____ Weight: _____

Insurance Info:

Primary Insurance: _____ Phone: _____

Member #: _____ Pays: _____ % Effective Date: _____

Coverage Details: _____

Co-Insurance: _____ Phone _____

Member #: _____ Pays: _____ % Effective Date: _____

COMPLETE THIS FORM AND SEND TO HCAV. WE WILL RESPOND TO YOU WITHIN 24 HOURS BY PHONE OR E-MAIL.