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 PhysicianDate 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.

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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.