Home Care Alliance of Virginia, Inc.

MEMBER PROVIDER REFERRAL FORM

Referral From ☐ **New Patient** ☐ **Add-On** ☐ **Change**

Source Company Name _____ Phone :_____

Name of Caller: _____ Date: _____ Time: _____

HCAV Provider Assigned ☐ **Member** ☐ **Affiliate** ☐ **Associate** ☐ **Out of Network**

Company: _____ Date Referred : _____ Time: _____

Patient Info

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

Address: _____ Phone: _____

City, State, Zip: _____ SSN: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Is This Patient's Permanent Address: ☐ Y ☐ N Facility: ☐ Home ☐ Nursing Home ☐ Retir. Home ☐ Other_____

Caregiver or Contact Person Info ☐ N/A

Name: _____ Relationship: _____ Phone #: _____

Address: _____

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

Name: _____ UPIN#: _____NPI#_____

Address: _____ Office Contact: _____

_____ Phone: _____

City, State, Zip: _____ Fax #: _____

Medical Info

Diagnosis: (1) _____ (2) _____

(3) _____ (4) _____

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

Infectious Disease Precautions: ☐ Bloodborne ☐ Airborne ☐ N/A

Other Agencies Involved: ☐ DME ☐ Hospice ☐ Nursing ☐ Rehab ☐ PT\OT ☐ Other: _____

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

Discharge date_____ Height: _____ Weight: _____

Insurance Info: **Bill HCAV for All Services.** The following is provided for info only.

Primary Insurance: _____ Member #: _____ Pays: 80 %

Effective Date: _____ Group # _____Coverage Details: _____

Prior Authorization Required ☐ Yes ☐ No

Deductable Met: ☐ Yes ☐ No Collect Payment on Delivery: ☐ Yes ☐ No

Co-Insurance: _____ Member #: _____ Pays: _____%

Equipment Order Info (Price is the contract fee or expected allowable for the item.)

	HCPCS	Description	Quantity	Price
1.	_____	_____		$: _____
2.	_____	_____		$: _____
3.	_____	_____		$: _____
4.	_____	_____		$: _____

FAX CONFIRMATION OF DELIVERY TO HCAV - BILL HCAV USING YOUR DATE OF SERVICE

CSR: _____ **A:** _____