AccessMed
ACCESS TO QUALITY HEALTHCARE FROM THE COMFORT OF YOUR HOME

Referral Form
Fax to: 713-714-4762
Info@accessmedhealthcare.com

Transition Patient ☐ **Primary Care Patient** ☐ **Date**_____

DC Date _____

Patient must have been discharged from a healthcare facility within the last 24 hours

Patient needing Primary Care services and has not been discharged from a healthcare facility within the last 48 hours

Contact Name: _____ **Telephone:** _____ **Fax:** _____

Email Address:_____

PATIENT INFORMATION

Patient Name: _____

DOB:_____/_____/_____: SSN: _____-___-_____Sex: ___M ___ F Phone: _____

Address: _____Facility Name: _____

Building #____ or Apartment #:____ City: _____ State:____ Zip: _____

Alternate Contact: _____ Relationship: _____ Phone: _____

MEDICAL INFORMATION

Medical Reason for Referral and Primary Diagnoses:

Is the patient seeing a primary care physician currently? ☐ Yes ☐ No Name of PCP _____

If yes, is the patient willing to see one of our Providers? ☐ Yes ☐ No

Is the patient receiving Home Health or Hospice Services? ☐ Yes ☐ No

Name of Home Health or Hospice Agency _____ Phone: _____

Is a face-to-face certification needed? ☐ Yes ☐ No

If yes, date of last certification period? Start Date _____ End Date _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____

ID#: _____ Group # (if applicable): _____ Effective Date: _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Carrier: _____

ID#: _____ Group # (if applicable): _____ Effective Date: _____

Referral Signature_____ Date:_____