NEW PATIENT REFERRAL FORM

Phone: 877-468-7322
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usmmpatientregistration@usmmllc.com

PATIENT NAME *(LAST)*:________________ *(FIRST)*:________________ *(MI)*: ________
ADDRESS: ________________ APT / BLDG #: ________
CITY:________________ STATE:________ ZIP:________ - ________
❑ *HOME* ❑ *APARTMENT* ❑ *DOMICILIARY* NAME OF FACILITY / APT: ________________
PATIENT PHONE:________________ IS THIS THE NUMBER TO CALL WHEN MAKING APPTS: ❑ *YES* ❑ *NO*
PATIENT EMAIL: ________________
SSN:________________ DATE OF BIRTH:________________ GENDER: ❑ *MALE* ❑ *FEMALE*
MARITAL STATUS: ❑ *SINGLE* ❑ *MARRIED* ❑ *WIDOWED* ❑ *DIVORCED* NAME OF SPOUSE: ________________
IN THE EVENT OF AN EMERGENCY CONTACT: ________________
RELATION TO PATIENT:________________ PHONE: ________________

DOES THE PATIENT HAVE A POA / GUARDIAN: ❑ *YES* ❑ *NO (SKIP THIS SECTION)* LEGAL STATUS: ❑ *POA* ❑ *GUARDIAN*
NAME:________________ RELATIONSHIP: ________________
ADDRESS:________________ APT / BLDG #: ________
CITY:________________ STATE:________ ZIP:________ - ________
POA / GUARDIAN PHONE:________________ NOTIFY BEFORE EACH VISIT: ❑ *YES* ❑ *NO*

PATIENT DX/HEALTH ISSUES: ________________
SPECIAL VISIT INSTRUCTIONS: ________________
IS THE PATIENT LATEX SENSITIVE: ❑ *YES* ❑ *NO* IS THE PATIENT CURRENTLY BEING TREATED BY A PRIMARY PHYS: ❑ *YES* ❑ *NO*
IS THE PATIENT CURRENTLY ON OR RECEIVING: ❑ *HOSPICE* ❑ *HOME CARE* ❑ *AIDE SERVICES* ❑ OTHER: ________
NAME OF AGENCY PROVIDING SERVICES:________________ PHONE: ________________

HOW DID THE PATIENT HEAR ABOUT OUR SERVICES: ❑ *WORD OF MOUTH* ❑ *HHA* ❑ *AFC/ALF* ❑ *MARKETING* ❑ *OTHER*
REFERRING PARTY:________________ PHONE: ________________

MEDICARE:________________ EFFECTIVE DATE:________ HMO INVOLVEMENT: ❑ *YES* ❑ *NO*
PART B ELIGIBLE: ❑ *YES* ❑ *NO* OPEN MSP : ❑ *YES* ❑ *NO* VERIFICATION: ❑ *C-SNAP* ❑ *PHONE*
MEDICAID *(IF APPLICABLE)*:________________ EFFECTIVE DATE:________ HMO INVOLVEMENT: ❑ *YES* ❑ *NO*

OTHER INSURANCE CARRIER *(IF APPLICABLE)*: ________________
POLICY NUMBER:________________ GROUP NUMBER: ________________
TYPE OF POLICY: ❑ *HMO* ❑ *PPO* ❑ *TRADITIONAL* ❑ *PFFS* PHONE: ________________

IN-OFFICE USE ONLY

WAS THE PATIENT CORRECTLY NOTIFIED OF POSSIBLE CO-PAYS / INSURANCE COVERAGE: ❑ *YES* ❑ *NO*

DATE OF REGISTRATION:________________ ASSIGNED VPA PHYSICIAN: ________________
DATE OF FIRST VISIT:________________ CENTRICITY ACCOUNT NUMBER:________________
MAPSCO CODE (if applicable) ________________ REFERRAL COMPLETED BY: ________________