ALLIANCE
MOBILE MEDICAL SERVICES
Group NPI: 1851184881

- SERVING THE FOLLOWING COMMUNITIES -
Dallas | Ft Worth San Antonio Houston

NEW PATIENT REFERRAL

Date: _____

REFERRING FACILITY AND PROVIDER

Referring Facility: _____
Referring Provider: _____
Main & Contact Number: _____
Facility Fax Number: _____
Facility Address: _____
City: _____ State: _____ Zip:_____

PATIENT INFORMATION

First / Last Name: _____
Date Of Birth: _____
Biological Gender: Male Female
Residing Address: _____
City: _____ State: _____ Zip:_____
Mailing Address: _____
City: _____ State: _____ Zip:_____
Phone Number: _____
Email: _____
Power Of Attorney (POA): ○ YES ○ NO
POA / Caregiver Contact Name: _____
POA / Caregiver Phone Number: _____

REFERRAL DETAILS

Referral Type: ○ Wound Care ○ Routine Foot Care
ICD-10 Code: _____ Diagosis: _____
ICD-10 Code: _____ Diagosis: _____

INSURANCE INFORMATION

Insurance Provider Name: _____
Policy ID Number: _____
Policy Holder Name Listed: _____

ACCEPTED INSURANCES

Here are some insurances we work with:

Medicare
United Healthcare
aetna
BlueCross BlueShield
TriWest Healthcare Alliance
ambetter.
oscar
Medicaid
Molina Healthcare
Humana.

In addition to the plans listed above we work with their corresponding HMOs.

PRIMARY CARE

Org Name: _____
Provider: _____
Phone #: _____
Fax #: _____
Email: _____

REFERRAL PROCESS

- Fill Out Demo/Referral Sheet For Patient
- Fax Over The Following Documents:
  - Referral Form
  - Last Provider's Note
  - Image of Insurance Card - Front / Back
  - Image of ID - Front / Back
  - Notes from Recent:
    - Labs / Tests
    - Procedures