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