TOTALCARE2U

CARE IS OUR SPECIALTY

Referral Form
Fax to: 877-926-5332
Intake@totalcare2u.com

Date_____________

Transition Patient DC Date __________

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

Chronic Patient

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 physicians? ☐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

Insurance must be Medicare B or Medicare Advantage attach copy of cards if available

Medicare #: _______________________________

Secondary Insurance Carrier: ____

ID#: __________________ Group # (if applicable): ___________________ Effective Date: ______________

Referral Signature______________________________________Date:______________________________

Total Care 2U

PH: 877-868-2528
www.totalcare2u.com

MRKT-DEPT