ColumbiaDoctors | *Primary Care*
Nurse Practitioner Group

HOUSE CALLS REFERRAL FORM

Please to fax to 212-342-0093

Today's Date: [Date]			Do you have a PCP: [PCP]		
PATIENT INFORMATION					
Patient's last name: First:		Middle: [Choose an item]	Marital status: [Choose an item]		
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former name:	Birth date: [Birthday]	Age:	Sex: ☐ M ☐ F
Address:					
Social Security no. (last 4 digits) :	Home phone no.:		Cell phone no.:		
Mother's first name: Father's first name:	Medications list:		Allergies:		
Referred to House Calls program by (Please choose one option): ☐ [Doctor's name] ☐ Other					
Reason for referral:					
INSURANCE INFORMATION					
(Please give or send a copy of your insurance card with this form.)					
Person responsible for bill:	Birth date: [Birthday]	Address (if different):	Home phone no.:		
Is this person a patient here? ☐ Yes ☐ No		Is this patient in rehab/SNF?	☐ Yes ☐ No		
Please indicate primary insurance: [Choose an item] | Other:					
Medicare	Medicaid				
Patient's relationship to subscriber: [Choose an item] | Other:					
Name of secondary insurance (if applicable):		Subscriber's name:	Group no.:	Policy no.:	
Patient's relationship to subscriber: Self | Other:					
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.:	Work phone no.:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ColumbiaDoctors | Primary Care Nurse Practitioner Group or insurance company to release any information required to process my claims.

Patient/referee signature

Date