Visiting Physicians Association®
Bringing Integrated Health Care Home®

Thank you for the referral. We are in the process of registering & verifying the patient information to set up for VPA physician services that you requested. In the future please use the attached referral form for all referrals and fax directly to the Patient Access Registration department at 855-252-4445.

If you have any questions and/or concerns regarding a patient referral or the many services we offer for the homebound patient; please contact us directly at 877-468-7322.

NEW PATIENT REFERRAL FORM

Phone: 877-468-7322
Fax: 855-252-4445
Email:
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: _____