EVERCARE CHOICE

REFERRAL FORM

TO REFER

CALL 845-569-0500 ✦ Press 0 for Member Services
or FAX 845-569-1887 ✦ Attn: Member Services
or EMAIL memberservices@evercare.org

REFERRAL SOURCE INFORMATION

REFERRER _____ PHONE [ ] –

ORGANIZATION _____ DATE ___/___/___

REFERRAL INFORMATION

NAME OF ENROLLEE _____ PHONE [ ] –

ADDRESS _____

DATE OF BIRTH ___/___/___ GENDER ☐ Male ☐ Female SSN# ___–___–___

CONFLICT FREE ASSESSMENT COMPLETED ☐ No ☐ Yes DATE ___/___/___

MEDICAID# _____ ☐ Needs to apply for Medicaid

MEDICARE# _____ OTHER INSURANCE _____

HOME CARE PROVIDER [*if any*] _____

DESIGNATED REPRESENTATIVE _____

RELATIONSHIP _____ PHONE [ ] –

WHAT SERVICES ARE BEING REQUESTED

_____

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