AssuredExcellence

PRICEMDS REFERRAL FORM

AssuredPartners
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assuredexcellence@assuredpartners.com

Please include an image of the front and back of your insurance card with this form. In addition, include an image of the picture page of a current passport for the person receiving benefits.

Referral date: ____ / ____ / ____	AssuredPartners Contact Name:
Employer Name:	Are they covered under bundled rate program? ☐ Yes ☐ No

PATIENT INFORMATION

Name: First:	Last:		Patient SSN:
Address: Street:	City:	State:	Zip:
Home Phone:	Mobile Phone:		
Patient Date of Birth: ____ / ____ / ____	Patient Gender: ☐ Male ☐ Female	Patient Email Address:	
Primary Language:	Translation Services Required: ☐ Yes ☐ No		
If Policy Holder is different than Patient: Policy Holder Name:	Pat. Relationship to Pol. Holder:	Policy Holder SSN:	
Policy Holder Address: Street:	City:	State: Zip:	Policy Holder Gender: ☐ Male ☐ Female

INSURANCE INFORMATION

Benefit Plan Name:	Group Number:	ID Number:	Primary Plan Type:
Claims Address: Street:	City:	State:	Zip:
Have additional health insurance? ☐ Yes ☐ No	If you answered "Yes," is your Employer sponsored plan considered your primary coverage? ☐ Yes ☐ No	Is your plan a HDHP? ☐ Yes ☐ No (Ded. > $1,350)	

PRESCRIPTION INFORMATION

Name of Prescription:	Dosage:	Quantity required; daily/monthly or weekly:
Have you been taking this medication for at least 3 months? ☐ Yes ☐ No		

Please include an image of the front and back of your insurance card with this form. In addition, include an image of the picture page of a current passport for the person receiving benefits.

Please note that your employer may be aware that you have received benefits under the AssuredExcellence program, although no medical details will be released.

Patient Signature: _____ Date: ____ / ____ / ____