REFERRAL FORM

Phone:	**1-866-363-7847**	**Fax:**	**1-916-781-5611**
Interpreter:	interpreters@intermedccs.com	**Durable Medical Equipment**	dme@intermedccs.com
Transportation:	transportation@intermedccs.com	**Home Health:**	homehealth@intermedccs.com

Service Requested:

☐ DME & Supplies ☐ Home Health ☐ Transportation ☐ Translation

Referred by: **Authorization #:**
Date:
Company:
Address:
City: **State:** **Zip:**
Phone: **Fax:**

Billing Information (if different from above)

Company: **Client:**
Contact:
Address:
Phone: **Fax:**

Claimant Information:

Name: **Social Security #:**
Address:
Claim #: **Phone:**
Date of Birth: **Date of Injury:**
Employer: **Body Part:**

Physician Information:

Physician:
Phone: **Fax:**
Address:
City: **State:** **Zip:**

Additional Information:

Prescription Obtained: ☐ Yes ☐ No

Deliver/Transport to: (if different from above)

Name: **Phone:**
Address:
City: **State:** **Zip:**

Please attach all reports pertinent to this request *(Such as prescription, medical report, etc.)*

Additional Comments: