SEASON

Season Health Patient Referral Form

PATIENT INFORMATION

Patient Name

First, Last

Date of Birth MM/DD/YYYY

Patient ID

An ID oftentimes from your EHR - that we'll use when we need to report back on a patient

Address

Street Address

Street Address Line 2

City

State/Province

Zip Code

Email

Phone Number

- -

Reason for Referral (conditions, wellness)

Primary Diagnosis Code

ICD-10 code

Discharge Date (if available)

Additional Patient Information (e.g., allergies, benefits, etc.)

PATIENT INSURANCE INFORMATION

Insurance Name/Plan

Group #

Subscriber Name

Member ID #

Subscriber Date of Birth MM/DD/YYYY

PRIMARY REFERRER

Primary Referrer Name

First, Last

Email

Fax Number

- -

Phone Number

- -

REFERRING PROVIDER INFORMATION

Practice Group/Health System

Referring Provider Name

First, Last

Email

Office Address

Street Address

Street Address Line 2

City

State/Province

Zip Code

Fax Number

- -

Phone Number

- -

Electronically signed by

Date

MM/DD/YYYY

NPI

(10-digit number)

Please DO NOT send medical records. If medical records are needed we will request them.

Please fax the completed form to 1 (877) 794-1374, Attention: Season Health - Patient Referral.