



### Initial Referral Form

Referred by \_\_\_\_\_ Contact \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_

Program Type: U&R  Home Hemo  EPO Carve  Network  Negotiate

#### Patient Information

Patient's Name \_\_\_\_\_ ID#: \_\_\_\_\_ DOB \_\_\_\_\_

Insured's Name \_\_\_\_\_ ID#: \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Employer Group \_\_\_\_\_ Group Renewal Date \_\_\_\_\_

Primary Insurance \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

First Date of Dialysis \_\_\_\_\_ Is patient being evaluated for transplant? \_\_\_\_\_

#### Current Provider Information

Facility Name \_\_\_\_\_ Tax ID # \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

#### Case Manager Information

Case Manager \_\_\_\_\_ Please check box if no case management

Company \_\_\_\_\_ Email \_\_\_\_\_ Phone \_\_\_\_\_

#### Payor Information

TPA \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_ Contact \_\_\_\_\_ Email \_\_\_\_\_

Reinsurance Carrier \_\_\_\_\_ Group Specific Deductible \_\_\_\_\_ Deductible Met? \_\_\_\_\_

Existing Discount % \_\_\_\_\_ Claims Paid to Date \_\_\_\_\_

Is Provider in Network? \_\_\_\_\_ Out of Network? \_\_\_\_\_ PPO Name: \_\_\_\_\_

Is Plan ERISA? \_\_\_\_\_ Is the Plan grandfathered? \_\_\_\_\_

**\*\*Note: A Copy of the Group's SPD must accompany this referral\*\***

Additional Info:

**Please fax or email completed referral form, along with UB-92 and/or HCFA 1500 form, to the following secured Fax number: (208)-263-0824 or email to [claimreferral@dccinc-us.com](mailto:claimreferral@dccinc-us.com)**

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