



Initial Referral Form

Referred by	Contact	Phone	Email
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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 <input type="checkbox"/>
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

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