

## Easy Care Program - Referral

**Fax Completed Form To: 1-585-287-5483**  
**Telephone Number : 1-585-351-2277**  
**Toll-Free Number: 1-866-459-9311**

**PATIENT INFORMATION:**

Patient ID# \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Patient Name \_\_\_\_\_ Telephone # \_\_\_\_\_  
 Patient Address \_\_\_\_\_

Please Select One: Medicare Advantage     HMO     PPO

**CARE PROVIDED TO PATIENT:**

Primary Diagnosis: \_\_\_\_\_  
 Secondary Diagnosis: \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE of Referral Source**

\_\_\_\_\_  
**Date & Time**

***For Internal Use:***

Signature	Date	Time
Received CC:		
Received by DOCS:		
Received by Care Manager:		
Send Letter to MD - <b>Circle:</b> Yes    No		