Quit For Life™ Referral Form

FAX REFERRAL FORM

FAX NUMBER: 800-483-3114

FAX SENT DATE: _____

(*NOTE: All information is required for processing. If any data is missing, we will fax the form back to you for completion, which will delay service to the participant.)

PROVIDER INFORMATION

Clinic Name:_____

Health Care Provider:_____

Contact Name:_____

Fax Number: (_____) _____ Phone Number: (_____) _____

Comments:_____

SUBSCRIBER INFORMATION

Subscriber Name:_____ Member ID #: _____

Gender: ❑ M ❑ F Pregnant: ❑ Y ❑ N Date of Birth: _____/_____/_____

Home Address _____ City_____ Zip_____

Primary Phone: (_____) _____ ❑ home ❑ work ❑ cell ❑ other

Secondary Phone: (_____) _____ ❑ home ❑ work ❑ cell ❑ other

Health Plan Line of Business: ❑ HMO & POS ❑ EPO ❑ PPO

Language Preference: English ❑ Spanish ❑ Other _____

Tobacco Type (check all that apply): ❑ Cigarettes ❑ Smokeless Tobacco ❑ Cigar ❑ Pipe

_____ I am ready to quit tobacco and would like to be contacted.
(initial)

_____ I permit messages to be left when contacting me.
(initial)

Subscriber Signature _____Date: ____/____/_____

Please check below the BEST three-hour time frame during the week to be contacted. NOTE: The Quit For Life program is available seven days a week; call attempts over a weekend may be made at times other than during this three-hour time frame.

❑ 9 a.m.–12 p.m. EST (6- 9 a.m. PST) ❑ 12–3 p.m. EST (9 a.m.–12 p.m. PST) ❑ 3–6 p.m. EST (12–3 p.m. PST)

❑ 6–9 p.m. EST (3-6 p.m. PST) ❑ 9 p.m.–12 a.m. EST (6-9 p.m. PST)

Within this time frame, please call me on my: ❑ Primary phone ❑ Secondary phone ❑ Either

Confidentiality Notice: This facsimile contains confidential information. If you have received this facsimile in error, please notify the sender immediately by telephone and confidentially dispose of this material. Do not review, disclose, copy or distribute.