ver: 31Aug23

RPM Referral Form

Patient Information:

Patient Last Name: First Name: M.I. Suffix:

DOB: Gender Assigned at Birth: Gender Identity:

Home Address: City: State: Zip:

Device: ☐ BP Cuff ☐ Glucometer ☐ Scale ☐ Pulse Oximeter

Logistical Information:

Time Zone: ☐ Check if Mail Address is the same as above.

Mailing Address: City: State:

Mobile Number: Allows Text? Home Phone:

Work Phone: Email Address: Language?

Emergency Contact Information:

Emergency Contact Name: Emergency Contact Phone:

Relationship to Patient: Preferred Contact Method?

Insurance Information:

SSN: Medicare/Medicaid MBI:

Medicare Supplement Policy Member ID: Expiration Date:

Provider Services Phone (from back of Insurance Card): Company:

Other Insurance Carrier: Member ID: Group No:

Provider Services Phone (from back of Insurance Card):

Patient Data: ☐ Check Box if Patient uses a Pacemaker or Defibrillator

Patient Weight Patient Height: Active COVID Patient?

Please list 2 qualifying comorbidities:

PCP Name: PCP Phone:
Pharmacy Name: Pharmacy Phone:
Specialist Name: Specialist Phone:
Other Provider: Other Provider Phone:

Comments: