CENTERS PLAN FOR HEALTHY LIVING

REFERRAL/SUBMISSION/FORM

Eli Kriger: ekriger@centersplan.com
Senior Manager of Business Development
Secure Fax: (347) 505-7084
Cell: (718) 490-3615

Referral Instructions:
Best time to contact Patient – Check One
☒ Day ☐ Evening
Other Instructions/information details here:

Referred By: **Bari Home Care** **Referral Date:** **04/24/2024**
Address: **37-16 73rd Street, Jackson Heights, NY, 11373**
Phone: **(718)-898-7100** **Fax: (646)-630-9581**
Email Contact: **Info@Barihomecare.com**

CLIENT REFERRED TO CPHL **CHECK APPROPRIATE BOX**

Name: **BEGUM, U K** Address: **145-20 LAKEWOOD AVENUE 2 JAMAICA, NY 11435** Phone: : Current Location of Patient:	**Sex** ☐ Male ☒ Female **X** **Marital Status** ☐ Married ☐ Widowed ☐ Divorced ☐ Single ☐ Separated **Date of Birth:** **03/01/1950** **Age:** **Is Patient aware of referral:** ☒ Yes ☐ No
Client Lives Alone ☐ Yes ☒ No **Animals / Pets** ☐ Yes ☒ No	**Primary Language:** **English-Speaking:** ☒ Yes ☐ No

ADVOCATE / HOUSEHOLD MEMBERS / SIGNIFICANT OTHERS / EMERGENCY CONTACT

Name	Relationship	Phone

Client's Social Security Number:

Medicare #:

Medicaid #: **MD75779Z**

PRIMARY CARE PHYSICIAN:
Address: Phone:
NPI: License:

PATIENT PRIMARY DIAGNOSES:

AGENCIES CURRENTLY SERVICING PATIENT **CFEEC**

Name of Agency: **SAIFUL** Type:	To Be Completed Only by Marketers/LHCSAs: **CFEEC required:** ☐ YES ☒ NO **X** **Maximus transferred and scheduled:** ☐ YES ☐ NO **If YES, CFEEC scheduled for:**

**Please ensure appropriate authorization was received to disclose the information to CPHL.*