A PRIMARY CHOICE, INC.

REFERRAL FORM

Email form to Shannon Oxendine, Chief Operating Officer: slane@primaryhealthchoice.org
or Fax to: 910-865-3874 Corporate Phone: 910-865-3500

Services

☐ Personal Care Services ☐ CAP-DA ☐ Veterans Care Program ☐ CAP-C

☐ EPSDT ☐ Respite Care ☐ Personal Emergency Response System

Does client have Dementia/Alzheimer's ? YES ◯ NO ◯

Client Information

First Name _____ Last Name _____

Date of Birth _____ Phone _____

Email _____

Address: Street _____ City _____

County _____ Zip Code _____ *Responsible Party for Client* _____

Insurance Information

Does client have Medicaid? YES ◯ NO ◯ Other insurer/payor _____

Medicaid ID _____

Referral Source

☐ Other Provider Agency ☐ CME ☐ Physician ☐ Relative

☐ Veterans Affairs ☐ Primary Care Other: _____

Information of Person Making Referral:

Full Name _____

Phone _____ Email _____