KC Safety Net Patient Referral Form

Date: _____ Time: _____

Referral Agency: _____

PATIENT INFORMATION:

Patient name: _____ MR#: _____ DOB: _____

SSN: _____ Gender: _____ Race: _____ Phone #: _____

Address: _____ City: _____

State: _____ Zip: _____ Alternate phone #: _____

If applicable, Parent or Guardian name: _____

Special Needs: _____ (i.e. wheelchair, interpreter, transportation to appointment)

Reason for Referral/Symptoms/Diagnosis: _____

Orders: _____

Refer to Clinic/Service/Location: _____

Referring Provider: _____ Title: _____

Signature: _____

UPIN: _____ NPI #: _____ Physician Specialty: _____

Office Phone: _____Office Fax: _____

Contact Person: _____Contact Phone #: _____

Does Patient have insurance? ☐ Yes ☐ No

INSURANCE INFORMATION:

Plan Name: _____

Subscriber Name: _____

ID #: _____ Group #: _____

Authorization #: _____ PCP: _____

Guarantor: _____

In order to assist the patient the following information should be obtained prior to their visit.
Please check and submit all pertinent documents electronically or mark not applicable (N/A):

Clinic intake form	**Applicable**	**N/A**	**Medicaid Denial Letter**	**Applicable**	**N/A**
ED records (recent)	**Applicable**	**N/A**	**Operative reports**	**Applicable**	**N/A**
ENT report	**Applicable**	**N/A**	**Ophthalmology records**	**Applicable**	**N/A**
History and Progress Notes	**Applicable**	**N/A**	**PAP report**	**Applicable**	**N/A**
Imaging	**Applicable**	**N/A**	**Pathology reports**	**Applicable**	**N/A**
Insurance Card.Photo copy	**Applicable**	**N/A**	**Photo ID. Photo copy**	**Applicable**	**N/A**
Labs	**Applicable**	**N/A**	**Physical therapy**	**Applicable**	**N/A**
Report of previous x-ray films pertaining to this diagnosis and referral				**Applicable**	**N/A**

METROCARE Specialty Care
Phone: (816) 531-8432 Fax: (816) 531-8438 Email: specialty@ncmc.cernerdirect.com

MetroCare Eligibility:
County of Residency: ☐ Clay ☐ Jackson ☐ Platte

Resident of selected county at least 3 months:	☐ Yes	☐ No
Uninsured	☐ Yes	☐ No
Income is below 400% poverty level	☐ Yes	☐ No
Medicaid denial letter on file	☐ Yes	☐ No

Reason(s) why is patient **not** eligible for discounted services at Truman Medical Center?
_____
_____

TRUMAN MEDICAL CENTER Consult Referral Center
Phone: (816) 404-0031 Fax: (816) 404-0013 Email: tmccrc@tmc.cernerdirect.com

Please have the patient bring the following items to apply for a discount and/or Medicaid:

- Proof of Address (e.g. water, phone bill)
- W2 forms and/or bank statements
- Social Security card or state issued ID card

Notes: _____
_____

Save or print a copy of this form before submitting it electronically.