CareLink
One partner for community and post-acute solutions.

Mobile Healthcare Authorization/Referral Form

Fax completed form, Primary Care Provider's order, copy of insurance card(s), current medication list, and recent H&P to **(401) 432-6687** to request services.

Facility: _____ Location\Unit Number: _____ Requester Name: _____

Address: _____

Services requested: (check all that apply):

☐ Audiology ☐ Dentistry ☐ Optometry ☐ Podiatry ☐ Rehabilitation ☐ Psychiatry

Please note reason for referral/Chief Complaint_____

Resident/participant information:

Name: _____
Last First Middle Initial

Gender: ☐ Male ☐ Female ☐ Decline to Answer

Date of Birth: _____ Social Security Number: _____

Medical/dental insurance information:

_____
Insurer Policy #

_____
Insurer Policy #

_____
Insurer Policy #

Consent for treatment for services checked above:

By signing below, I or my substitute decision maker agree to treatment by a CareLink clinical provider.

☐ Patient or ☐ Health Care Proxy:

Signature: _____ Date: _____
Name: _____ Relationship: _____
Telephone: _____ Email: _____

☐ Staff Receiving Verbal Consent: _____
Name/Signature Title

Consent for billing/payment:

I hereby assign all health insurance benefits to CareLink for services rendered. This assignment includes benefits payable by Medicaid and all other insurance programs of which I/the resident am/is a beneficiary. I authorize the release of all information from all sources necessary to secure payment. I understand that I am responsible for any fees and/or co-payments not covered by insurance.
I also acknowledge that I have received the CareLink Notice of Privacy Practices.

☐ Patient or ☐ Financially Responsible Party

Signature: _____ Date: _____
Name: _____ Relationship: _____
Address: _____
Telephone: _____ Email: _____

☐ Staff Receiving Verbal Consent: _____
Name/Signature Title