

Patient Referral Request Form

Please complete the form below and a Prime Care Health Solutions team member will contact you to complete your request. For assistance completing this form, please contact us at 214-613-2019.

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Select the program or service you'd like to refer your patient to at Prime Care Health Solutions

- ☐ Comprehensive Pharmacy Concierge Service (medication management & adherence & lifestyle coaching)
- ☐ Medication Management
- ☐ Medication Reconciliation & Reduction Service
- ☐ Smoking/Tobacco Cessation Program
- ☐ Opioid Addiction Prevention Program
- ☐ Tele-health Pharmacy Disease Management Program
- ☐ Hypertension Management Program
- ☐ Hypertension Prevention Program
- ☐ Diabetes Management Program
- ☐ Lifestyle Wellness Programs (events, workshops & classes)
- ☐ Workplace Wellness Program
- ☐ Weight Management Program
- ☐ Private 1-1 Health & Wellness Coaching Service
- ☐ Women's Health Coaching Service
- ☐ Family Planning – Hormonal Care & Fertility Care service
- ☐ Men's Health Coaching Service
- ☐ DPP

Referring Physician Information

Provide information about the provider requesting the referral

Your First Name	Your Middle Name	Your Last Name
NPI Number	Specialty	

Practice Contact Information

Provide information about the contact person for a referral

Last Name*	First Name*	Title
Clinic / Facility Name*	Clinic / Facility Address	City*
Phone number	Fax	Your E-mail Address

Patient Information

Appointment Information

Primary Care Physician

Primary Pharmacy

Payment / Insurance Options

Who will be covering the cost of the service(s) you selected?*

If you are covering the cost by yourself, you will be redirected to a page where you can complete your enrollment and make a payment.

☐ Myself (out of pocket) ☐ My Insurance ☐ My Employer through a company wellness program

Your medical insurance information

Please provide your medical insurance information for the selected service(s). Insurance name, primary carrier's name (insured), member ID number, group number, coverage date, effective date and customer service number.

Your pharmacy insurance information

Please provide your pharmacy insurance information for the selected service(s). Insurance name, primary carrier's name (insured), member ID number, BIN number, group number, coverage date, effective date and customer service number.

Employer information*

Please provide the following details for your employer: Company name, company address, contact email, phone number.