REFERRAL FORM

FAX to 503-616-7174
or
Secure Email to: triage@6degreeshealth.com

Referral Contact Information

Contact First Name
Contact Last Name
Company Name

Contact Email Address
Contact Phone Number

Patient Information

Patient First Name
Patient Last Name
Mailing Address
City/State/Zip

Gender Male Female
Date of Birth
Diagnosis
Procedure

Provider/Hospital Information

Hospital Name
Patient currently being treated at Hospital? Yes No
Evaluation Date

Health Plan Information

Plan Name
Member ID
Group Number
Plan Type
TPA Name
TPA Contact
Case Management
CM Contact
Stop-Loss Carrier

Cost Containment Information

DRG (if known)
Existing Network
Network Discount
Claim Network Status
Requested Services:

Additional Comments