

Fax Referral Form

Care Management Program

Phone: (800) 491-0909

Fax: (844) 381-6782

Email: Call_Center@LTCHS.com

Patient Information (Please Print):

Date: _____

First Name:	M.I.	Last Name:
Family Contact:	Contact Number:	
Home Health Agency:	Contact Number:	
PCP:		

Referrer Information (Please Print):

Facility Name:
Contact Person:
Contact Number:

Please attach the following items:

- FACE SHEET
- H & P
- DISCHARGE SUMMARY
- CURRENT MEDICATION LIST

*Our Care Management Coordinators will call your referral. Please check the **BEST** time frame for them to be reached:*

- 9 A.M. - 12 P.M.
- 12 P.M. - 3 P.M.
- 3 P.M. - 6 P.M.
- 6 P.M. - 9 P.M.

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