UMass Memorial Health

Physician Concierge Services - Intake Form
Telephone: 800-431-5151 / 508-856-5656 Fax: 508-334-7616: 508-334-8317: 508-334-1486 Today's Date:

PCP / Referring MD:
Phone:
Fax:
Contact Name:

Priority of Request: (check one below)

☐ Urgent [24-48 hrs.] ***Medical Reason for Urgency**
***Requires clinical notes & recent imaging**
☐ ASAP [7-10 days]
☐ 2nd Opinion
☐ Consult

Interpreter Needed: Y N
Language:

Specialty Clinic:

Preferred Provider:

Preferred Location:

PATIENT:

DOB: **SEX:**

ADDRESS:

EMAIL:

PHONE: (H) **(C)**

PRIMARY INSURANCE:

POLICY NUMBER:

GUARANTOR (NAME/DOB):
(UNDER 18)

SECONDARY INSURANCE:

POLICY NUMBER:

GUARANTOR (NAME/DOB):
(UNDER 18)

SUBSCRIBER (NAME/DOB):

RACE:
American Indian or Alaska Native _____
Asian_____
Black or African American_____
Hispanic or Latino____
Not Hispanic or Latino_____
Native Hawaiian or Pacific Islander____
White___
Decline to Answer___

ETHNICITY OR ETHIC BACKGROUND
American ____
Brazilian _____
Korean _____
Other_____

Decline to Answer_____

****Note: To expedite scheduling appointments, please make sure the following information is sent to PRS.**

- Complete and fax any clinical notes, labs, x-rays, MRI's, Cat Scans.
- Questionnaires for Mammography, Cat Scans, Nuclear Med must be filled out and faxed with referrals.

Diagnosis: **ICD 10 CODE:**

Prior Authorization:
Dates: **Contact Name:**
Number of visit: **Telephone:**

***Required for MRI's and CT Scan's**

MVA / Worker's Comp: **Date of Injury:**
Claim Number:
Insurance Co:
Address: **Telephone:**