Blue Advantage
A Medicare Approved PPO

Serious Illness
CARE PROGRAM
Support for Providers

Serious Illness Care Program Patient Referral Form

Fax this form to: 205-220-9520

Note: ALL fields must be completed for the referral to be processed.

Patient Information

Name:			Date:
DOB:	Sex:		Contract ID:
Street Address:			
City:		State:	Zip Code:
Phone (Home):		(Cell):	
Email:			
Caregiver Name: *(If Applicable)*			Caregiver Phone:
Diagnosis: *Click Applicable Diagnosis*	Chronic Heart Failure (Stages 3 and 4) ESRD (Dialysis Patients Only) Dementia Chronic Obstructive Pulmonary Disease (Stage 4) Metastatic Cancer Other		If "Other," Please Specify:

Referring Provider Information

Referring Provider:	Specialty:
Nurse/Office Contact:	Phone:
Provider ID:	Provider NPI:

Referral Reason