Center for Health Care Rights

CLIENT REFERRAL FORM

Referral From:

Name:_____

Agency:_____

Phone:_____

Email:_____

Please use this referral form to refer clients who have Medicare, Medi-Cal or related health insurance problems. The referral should be sent to CHCR by secure email to referrals@healthcarerights.org ; or by Fax to (213) 383-4598.

DATE:_____

CLIENT INFORMATION

NAME (include middle initial/suffix, if applicable):_____

ADDRESS:_____

CITY:_____ **ZIP:**_____

PHONE:_____ **EMAIL:**_____

PRIMARY LANGUAGE:_____

Best Way to Contact: ☐ **Phone** **or** ☐ **Email**

CONTACT NAME:_____

PHONE:_____

EMAIL:_____

RELATIONSHIP TO CLIENT:_____

CONTACT'S PRIMARY LANGUAGE:_____

Best Way to Contact: ☐ **Phone** **or** ☐ **Email**

REASON FOR REFERRAL: Provide a brief description of the client's questions or concerns below.

_____

_____