



Referral From: Name: _____ Agency: _____ Phone: _____ Email: _____

CLIENT REFERRAL FORM

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 chcreferral@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.
