



Emerging Therapy Solutions® (ETS) New Referral Form

Requested ETS Effective Date*: _____

Please return completed form by email to clientservices@emergingtherapies.com or fax to 612-445-5649. Our Client Services team member will contact you upon receipt. Thank you!

Patient & Subscriber Information

Patient/Member Name*: _____

Member ID*: _____ Patient DOB*: _____

Subscriber Name (if different than patient)*: _____ Subscriber ID*: _____

Coverage Type: ☐ Commercial ☐ Exchange ☐ Medicare Advantage ☐ Managed Medicaid

Service & Facility Information

Service Type*: _____ Diagnosis*: _____

Facility*: _____ Evaluation Appointment Date: _____

Benefits Contact

Company*: _____ Phone*: _____

Contact*: _____ Email*: _____

Claims Administrator

Company*: _____ Phone*: _____

Contact*: _____ Email*: _____

Claim Company Physical Address: _____

Method of Claim Receipt: ☐ EDI 837 file ☐ Transport Layer Security (TLS) Encrypted Email ☐ Secure File Transfer Protocol (SFTP) ☐ US Mail

Availity Payer ID: _____
*required for 837 file delivery

Medical Case Manager

Company: _____ Phone: _____

Contact: _____ Email: _____

Reinsurance, Stop Loss Carrier or MGU

Company: _____ Name: _____

☐ Fully Funded/Insured ☐ Self-Funded/Insured

Employer Group

Submitted By (Your Contact Information):

Your Name*: _____ Company*: _____

Phone*: _____ Email*: _____

Comment: _____

*Denotes a required field. Note that either a phone or email is required for contact information but not necessarily both.

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