Emerging Therapy Solutions® (ETS) Referral Form

Please return completed form by fax to **612-445-5649** or by email to medicalservices@emergingtherapies.com. Our Medical Services team member will contact you upon receipt. Thank you for accessing ETS

Date of Referral: _____

Patient and Subscriber Information

Patient Name: _____ Patient ID: _____ DOB: _____

Subscriber: _____ Subscriber ID: _____

Coverage Type: _____

Facility and Service Information

Facility: _____ Diagnosis: _____

Service Type: _____ Evaluation Date: _____

Reinsurance or Stop Loss Carrier Information

Company: _____

Employer Group

Name: _____

Benefits Contact

Company: _____ Phone: _____

Contact: _____ Email: _____

Claims Administrator

Company: _____ Phone: _____

Contact: _____ Email: _____

Claims Address: _____

Medical Case Manager

Company: _____ Phone: _____

Contact: _____ Email: _____

Submitted By (Your contact information):

Your Name: _____ Company: _____

Phone: _____ Email: _____

Comment: _____