Emerging Therapy Solutions® (ETS)
New Referral Form

Requested ETS Effective Date: _____

Please return completed form by email to medicalservices@emergingtherapies.com or fax to 612-445-5649. Our Medical 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: ☐ Transport Layer Security (TLS) Encrypted Email ☐ Secure File Transfer Protocol (STFP) ☐ US Mail

Medical Case Manager

Company: _____ Phone: _____

Contact: _____ Email: _____

Reinsurance, Stop Loss Carrier or MGU

Company: _____

Employer Group

Name: _____

☐ Fully Funded/Insured ☐ Self-Funded/Insured

Submitted By (Your Contact Information):

Your Name: _____ Company: _____

Phone: _____ Email: _____

Comment: _____

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