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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