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: ☐ 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: _____

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

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