Referral Form

Patient Information

Full Name: _____

Date of Birth: ____ / ____ / _____

Phone Number: _____

Address: _____

Referring Provider Information

Provider Name: _____

NPI #: _____

Phone: _____

Fax: _____

Clinic/Facility Name: _____

Clinic Email: _____

Care Team Contacts (Optional – for coordination of care)

1. Name: _____ | Email: _____

2. Name: _____ | Email: _____

3. Name: _____ | Email: _____

Devices Requested (Check all that apply)

□ Blood Pressure Cuff
□ Weight Scale (CHF, obesity, CKD)
□ Pulse Oximeter
□ Glucometer
□ Peak Flow Meter
□ Other: _____

Clinical Indications / Diagnoses (Select all that apply)

Common RPM-eligible conditions & ICD-10 codes.

Cardiac

□ I10 – Essential (primary) hypertension

□ I50.9 – Congestive Heart Failure (CHF), unspecified

□ I25.10 – Atherosclerotic heart disease

□ R00.1 – Bradycardia

□ I49.9 – Cardiac arrhythmia, unspecified

Diabetes

□ E11.9 – Type 2 diabetes without complications

□ E11.65 – Type 2 diabetes with hyperglycemia

□ E10.9 – Type 1 diabetes without complications

Pulmonary

□ J44.9 – COPD, unspecified

□ J45.909 – Asthma, unspecified

□ R06.02 – Shortness of breath

Obesity / Metabolic / Endocrine

□ E66.9 – Obesity, unspecified

□ R73.03 – Prediabetes

□ E78.5 – Hyperlipidemia, unspecified

Renal

□ N18.9 – Chronic kidney disease, unspecified

RPM/CCM Services

[ ] Remote Patient Monitoring

[ ] Chronic Care Management

[ ] Behavioral Health Integration

Other (write-in ICD-10 or clinical reason):

Duration of Time: 0-99 months_____.

Monitor how many times a day: _____.

Other (write-in ICD-10 or clinical reason): _____

_____.

HIPAA Compliance & Authorization to Bill

I acknowledge that I have been informed of my rights under the Health Insurance Portability and Accountability Act (HIPAA). I consent to the secure collection, transmission, and use of my health information for medical monitoring, treatment, and billing purposes.

I authorize Community Strong LLC and its billing partners to submit claims to my health insurance for Remote Patient Monitoring (RPM) services rendered and to receive direct

payment for these services. I understand that my insurance may be billed monthly for monitoring services and I may be contacted by a health coach or clinician.

Patient Consent
Verbal Consent Given (initial by provider: _____
Patient Signature: _____ Date: ____ / ____ / _____
Provider Signature: _____Date: ____ / ____ / _____