Community Care
OF NORTH CAROLINA
Community Health Partners

Provider Referral Form

Patient Information:

Name: _____

Date of Birth: _____ Medicaid ID Number: _____

Address: _____

Phone Number: _____

Reason for Referral:

_____

_____

_____

_____

_____

Pertinent Medical History:

_____

_____

_____

_____

Provider Contact Information:

Practice Name: _____

Contact Person: _____

Telephone Number: _____

Fax referral to attn.: Patient Educator at 704-865-4614