Nursing Facility Referral Form

Date of referral: _____/____/_____
Month Day Year

Name of referred resident:

Last_____ First_____ MI_____

DOB_____/_____/_____ Health Plan Member ID _____

Resident Representative/Designee/Power of Attorney:

Last_____ First_____

Phone (_____) _____-_____ Relationship to resident_____

Comments :

_____

Referred by:

Nursing Facility _____ NF/SNF Provider # _____

City: _____ State: _____

(_____)_____-_____ _____
Phone Contact Name

Please check appropriate box below and fax referral to:

If resident **is** currently eligible for Medicaid:

_____ UnitedHealthcare **1-888-582-1963**
_____ AMERIGROUP **1-888-762-3203**
_____ BlueCare/TennCare Select **1-615-565-1993**

If resident is **not** currently eligible for Medicaid:

_____ First TN AAAD…….. 1-423-926-8291
_____ South Central TN AAAD……. 1-931-379-2685
_____ East TN AAAD…….. 1-865-251-0076
_____ Northwest TN AAAD…… 1-731-587-6744
_____ Southeast TN AAAD…… 1-423-648-9274
_____ Southwest TN AAAD…….. 1-731-668-6438
_____ Upper Cumberland AAAD…….. 1-931-432-8112
_____ Aging Commission of the Mid-South AAAD…… 1-901-222-4199
_____ Greater Nashville AAAD……. 1-615-862-8876