ClaimAid

A Service of ClaimAid Client

# Patient Referral Form

**Patient Name:** _____

**Phone Number:** _____

**Additional Phone Number:** _____

**Best Time to Contact:** _____

**Additional Information:** _____

_____

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_____

**Please send this completed form and any additional documents to:**

BY EMAIL : referral@claimaid.com

BY FAX : 317-897-9005

Questions?
Contact us at:

800-842-4052
**ClaimAid Advocate**
**8141 Zionsville Rd**
**Indianapolis, IN 46268**