tricarembhresourcesconsultant@gmail.com 240-300-3220

Consultation Request Form

Full Name *

First Name Last Name

Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Phone Number *

Email

Insurance Type

(Tricare Prime, Select, Tricare Prime Remote, VAMC)

Do you have a New Referral or Authorization

- ☐ Yes
- ☐ No
- ☐ Unsure

Referral or Authorization Information

What is your Status? *

- ○ Active
- ○ Retired
- ○ Veteran

Primary Care Provider Information

(Location and Phone Number)

Please describe your request for services

(examples: appointment, DME, BH or case management)

Please provide your preferred appointment dates and time