Polara Health
GUIDING YOUR WAY TO WELLNESS SINCE 1966

Client Referral to Polara Health

Referral Date:_____ Referral Source: _____

Client Name:_____ DOB:_____ Age:_____

Gender at Birth: M____F_____ Gender Identity: _____

Guardian Name (If Applicable): _____

Relationship:_____

Contact Number:_____ Email address (if applicable):_____

Physical Address:_____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone:_____

Insurance Information:

AHCCCS ID:_____ AHCCCS Health Plan:_____

Other Insurance Plan: _____ Policy #: _____

Group #:_____ Policy Holder: _____

Preferred Clinic Location:

_____ Prescott _____Prescott Valley _____Chino Valley _____Verde Valley

All Referrals will be contacted within 1 business day and offered an intake within 7 days.

Reason for Referral:_____

_____

_____

Please fax the completed Referral Form to: 928-445-0126