

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