Hamaspik Inc.

HAMASPIK MEDICARE CHOICE (MAP) Consent to Contact Form

Form can be sent via fax or Email: enroll@hamaspikchoice.org

Direct Phone: 833-426-2774; Extension: 605; Direct Fax: 845-503-1546

Date of Referral*:	**Agency Contact Info:** **Name*: _____ Agency*: _____ Phone*:**				
APPLICANT INFORMATION					
Last Name*:	**First Name*:**		**DOB*:**		
Primary Language(s) (if not English)*:					
Home Phone*:	Cell Phone:		Best time to contact:		
Street*:	Apt:	City*:	State*:	Zip Code*:	
HEALTH INSURANCE					
Medicaid #*:	Other health insurance(s) (include MLTC) if applicable:				
Medicare #*:					
CAREGIVER/EMERGENCY CONTACT INFORMATION					
Name (1):	Relationship:	Phone #			
Name (2):	Relationship:	Phone #			
PHYSICIAN INFORMATION	If the individual has multiple specialists, please add to the second sheet.				
PCP Name/Group*:	**PCP Phone*:**				
Street*:	City, State, ZIP*				
Specialist(s) Name/ Group:	Phone:				
Street:	City, State, ZIP				
GENERAL INFORMATION					
Did Applicant have Maximus assessment?	If yes, Date?				
Additional Notes:					

Signature for Consent to Contact (Optional): _____

*Required Fields

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MAP - ADDITIONAL PHYSICIAN INFORMATION

ADDITIONAL PHYSICIAN INFORMATION	
Specialist(s) Name/ Group:	**Phone:**
Street:	**City, State, ZIP**
Specialist(s) Name/ Group:	**Phone:**
Street:	**City, State, ZIP**
Specialist(s) Name/ Group:	**Phone:**
Street:	**City, State, ZIP**
Specialist(s) Name/ Group:	**Phone:**
Street:	**City, State, ZIP**
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