Dear Sir or Madam:

Thank you for considering **Elite CMCS – Case Management Concierge Services, LLC,** where care is our highest priority. We appreciate your trust in our concierge case management services. Every service is delivered with discretion, clinical expertise, and personalized attention, ensuring a seamless, worry-free healthcare experience.

Once all required referral information and supporting documents are received, our team will review the case thoroughly and provide a proposed Plan of Care within 48 hours. The prospective Elite Member will then have 72 hours from receipt of the proposal to review and accept the offer.

Please note that for services involving medication administration, a Treating Physician order and a prescription for medications will be required before care can begin. Submission of this referral does not guarantee acceptance, as each case is evaluated individually.

Upon acceptance, the Elite Member will receive personalized access to our full range of services, including tailored A La Carte options, exclusive Subscription plans, and premium Membership benefits designed for seamless, high-touch care.

Should you have any questions regarding this referral, please contact us at elitecmcs@gmail.com or (917) 873-4544. We look forward to providing you with an unparalleled level of concierge healthcare.

Elite CMCS
175-61 Hillside Ave. Suite 202 Jamaica, NY 11432; Tele: +1 917-873-4544; Fax +1-347-426-9784
info@elitecmcs.com; www.EliteCMCS.com

ELITE CMCS

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Date of Referral: Click or tap here to enter text.	ID: Click or tap here to enter text.	Plan: Click or tap here to enter text.
Elite Member Information		
First Name: Click or tap here to enter text.	Middle Name: Click or tap here to enter text.	Last Name: Click or tap here to enter text.
Address: Click or tap here to enter text.		Apt. Click or tap here to enter text.
City: Click or tap here to enter text.	State: Click or tap here to enter text.	Zip: Click or tap here to enter text.
Home Phone Number: Click or tap here to enter text.	Cell Phone Number: Click or tap here to enter text.	E-mail: Click or tap here to enter text.
Date of Birth: Click or tap here to enter text.	Age: Click or tap here to enter text.	SSN: Click or tap here to enter text.
Sex: Click or tap here to enter text.	Primary Language:Click or tap here to enter text.	Race: Click or tap here to enter text.
Caregiver Information		
First Name: Click or tap here to enter text.	Middle Name: Click or tap here to enter text.	Last Name: Click or tap here to enter text.
Address: Click or tap here to enter text.		Apt. Click or tap here to enter text.
City: Click or tap here to enter text.	State: Click or tap here to enter text.	Zip: Click or tap here to enter text.
Relationship: Click or tap here to enter text.	E-Mail: Click or tap here to enter text.	Phone Number:Click or tap here to enter text.
Referral Information		
Treating/ Referring Provider (NPI): Click or tap here to enter text.	Provider Address: Click or tap here to enter text.	Provider Phone Number: Click or tap here to enter text.
Referrer Name/Title: Click or tap here to enter text.	Referrer Phone Number: Click or tap here to enter text.	Referrer Email: Click or tap here to enter text.
Referring Diagnosis: Click or tap here to enter text.		

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Reason for Referral:

☐ Consultation: Choose an item.
☐ Wound Care: Choose an item.
☐ Medication Management /Administration: Choose an item.
☐ Private Duty Nursing Care: Choose an item.
☐ Intravenous (IV) Nutrition: Choose an item.
☐ Intravenous (IV) Add Ons: Choose an item.
☐ Physiological Baseline Assessment: Choose an item.
☐ Bespoke Wellness and Lifestyle: Choose an item.
☐ Comprehensive Physical Exam: Choose an item.
☐ Administrative Forms: Choose an item.
☐ Nursing Concierge Care Membership- Exclusive. Personalized. Elevated- Join as an Elite Member to receive priority access, after-hours coordination, and premium support: Choose an item.
☐ Elite Subscription- Consistent Support. Personalized Oversight- Choose a weekly, monthly, or annual subscription for structured nursing services tailed to your ongoing needs.: Choose an item.
☐ A La Cart: $250 flat fee: Includes vital sign assessment, services, and documentation. Flexibility when you need it- Access individual clinical services on demand with transparent flat- fee pricing: Choose an item.

📎 **Required for Wound Care & Medication Services:**
Please attach insurance information, supporting clinical documentation, treating physician orders, medication lists, or wound photos.

HIPAA & Confidentiality Notice:
This referral form contains Protected Health Information (PHI) intended solely for the use of Elite CMCS – Case Management Concierge Services, LLC. This information is being disclosed in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and applicable New York State privacy laws. Unauthorized use, disclosure, or distribution is strictly prohibited. By submitting this referral, the sender attests that they have obtained all necessary patient authorizations to share this information with Elite CMCS for coordination of care.

Where to Return Referral Form:

Fax: 347-426-9784
E-Mail: Elitecmcs@gmail.com

REFERRAL FORM