VISION COVERAGE
OF COLORADO

PATIENT REFERRAL FORM

EMAIL TO: **PatientServices@VCCeye.com** FAX TO: **720-263-9142**
MAIL TO: **PO BOX 5391 - DENVER CO 80217**

Referral Date: _____/_____/______

PATIENT INFORMATION:

Name:_________________________________ Date of Birth _____/_____/_____

Address/Place of Residence:____

Phone: (_____)_____________ (please circle): HOME/ CELL/ WORK/ Not applicable

Patient Insurance: ____

Power of Attorney (if applicable): ______________________ Phone:(____)_________

REFERRING PROVIDER:

Name: ____________________________ Practice: ____________________________

Address: ____

Phone: (____)___________ FAX: (____)___________ Email: ____________________

Preferred form of correspondence for follow-up: ☐ Mailing Address ☐ Email ☐ FAX

REASON FOR REFERRAL:

☐ Pediatric Eye Exam ☐ Diabetic Eye Exam ☐ Blurred Vision

☐ Cataract Evaluation ☐ Macular Degen Eval ☐ Red Eye/Eye infection

☐ Dry Eye Evaluation ☐ Flashes/Floaters ☐ Low Vision Aids

☐ Other ____

Referring Provider Signature _______________________________ Date ___________

FOR URGENT REFERRALS PLEASE CALL: (720)-295-5356

Form updated 04/2019