VISION COVERAGE
OF COLORADO

PATIENT REFERRAL FORM

EMAIL TO: **PatientServices@VCCeye.com**

FAX TO: **720-263-9142**

Referral Date: _____/_____/_____

PATIENT INFORMATION:

Name:_____ Date of Birth _____/_____/_____

Address/Place of Residence:_____

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

Insurance Plan & ID_____

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 05/2023