

Date: ____/____/____

Please accept this referral to the CMS GUIDE Model Program from

Provider Name Printed _____ (MD, DO, APP)

For the Following Patient

First Name _____

Last Name _____

Date of Birth ____/____/____

This patient's most recent assessment date was ____/____/____

I attest that this patient has the following Dementia Diagnosis ICD-10 code(s)
Please check box next to the appropriate Dementia Diagnosis or add "Other"

<input type="checkbox"/>	Vascular Dementia	F01.50
<input type="checkbox"/>	Unspecified Dementia, Mild	F03.A0
<input type="checkbox"/>	Unspecified Dementia, Moderate	F03.B0
<input type="checkbox"/>	Unspecified Dementia, Severe	F03.C0
<input type="checkbox"/>	Alzheimer's Disease	G30.0
<input type="checkbox"/>	Pick's Disease: Frontotemporal Dementia	G31.01
<input type="checkbox"/>	Neurocognitive Disorder with Lewy Bodies	G31.01
<input type="checkbox"/>	Other _____	

Please include the following:

Patient's Demographics

Copy Medicare Parts A and B Identification Card

Most Recent Progress Note

Current Medication List

Provider Signature: _____ **Date:** ____/____/____

Fax to 928.458.2165

Thank you!