Lions Eye Institute at Albany, New York, Inc.
leialbany@gmail.com

Patient Referral Form

Date: _____

Patient:

Name _____ DOB _____ Age_____
Last First Middle
Home Address _____ City _____State ____Zip_____

Home Phone _____# of Dependents_____ Employer_____

Business Address _____City_____ State _____Zip_____

Business Phone _____Yrs Empl ___Annual Income _____

Spouse/Parent/Guardian:

Name _____DOB _____ Age_____
Last First Middle
Home Address_____City_____State___ _Zip_____

Home Phone _____# of Dependents _____Employer _____

Business Address_____City_____State ____Zip_____

Business Phone _____ Yrs Empl ___Annual Income _____

Total Annual Household Income_____

Insurance:
Applicant must attempt to obtain private, charitable or governmental health insurance such as Medicare, Medicaid, or Fidelis Care. If you need additional assistance, contact the Health Insurance Information Counseling and Assistance Program (HICAP) at 1-800-701-0501. Applicants who may require surgery and/or hospitalization must also apply to Albany Medical Center for financial aid. Please contact AMC's Patient Financial Services department at 518-262-1981 or 1-866-262-7476.

Ins. #1_____None_____Policy Number_____

Ins Address_____ City _____State ____Zip_____

Policy Holder Name_____ Relationship_____

over

Ins. #2 _____ Policy Number_____

Address_____ City _____State ____Zip_____

Policy Holder Name _____Relationship _____

Do you qualify for Medicaid? Yes _____ No _____. If no, please enclose a copy of the denial letter.

Description of Visual Problem:

_____

I, _____, authorize the _____Lions Club to refer the above stated patient to the Lions Eye Institute and to release the above information to the Lions Eye Institute and Lions Eye Institute Physicians, Albany Medical Center or other Lions Eye Institute approved medical facilities. I further release this Lions Club and the Lions Eye Institute of any legal or monetary obligation for their assistance in arranging for services. **Any financial assistance provided by the Lions Eye Institute shall be limited to a maximum total of $4,500 per patient.**

_____ _____ _____

Signature Relationship Date

Personal Physician and/or Eye Specialist:

Name_____Speciality_____ Phone _____

Name_____Speciality_____ Phone _____

Lions Club:

Club Name_____ Lions District #_____

Club Address_____City_____State____Zip_____

Referring Members Name_____

Telephone _____ Email_____

President's or Secretary's signature _____

IMPORTANT: Forms must be completed in full before they can be processed. Referrals must be made through the appropriate local Lions Club. Incomplete forms or forms sent directly to the Lions Eye Institute will delay care and/or may result in denial of the referral.

Once the patient has completed his/her part of the form it should be forwarded to the Sight Chairman of the appropriate local Lions Club for approval at the Club level.

Once the referral is approved and signed off by the Lions Club the completed forms must be forwarded to:

For patients/Lions Clubs in **District 20-O**

PDG Lion Wilfred Roehe
9 Skyview Drive
Poughkeepsie, NY 12603

With copy to:
VDG Lion Barbara Gavin
159 South Quaker Lane
Hyde Park, NY 12538

For patients/Lions Clubs in **District 20-Y2**:

Lion Phil Klein
29 Walter Drive
Saratoga Springs, NY 12866

With copy to:
Lion John McDonald
P.O. Box 91
Galway, NY 12074

For patients/Lions Clubs in **District 20-W**:

PDG Lions Liz & Bob Walker
66 East Church Street
Adams, NY 13605

With copy to:
PDG Lion Wilfred Roehe
9 Skyview Drive
Poughkeepsie, NY 12603