MED3000 Physician
Referral Form

Physician Name: _____

Practice Name: _____

Address: _____

City/State/Zip: _____

Contact Person: _____

Preferred Phone: _____

Email Address: _____

When do you want to be contacted?

_____48 Hours _____1 Week _____1 Month

Best Contact Method?

_____Mail _____Email _____Phone

Referring Market CEO or ED: _____

Contact Phone: _____

What MED3000 Products are you interested in?

_____Payer Enrollment _____Revenue Cycle Management

_____EMR _____Practice Management Consulting Services

_____In-House Practice Management System (InteGreat PM)

MED3000 Physician Referral Form should be faxed to:
Kindred Healthcare, Inc.
Attn: Katy Carter
(502) 596-4084