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REFERRAL REQUEST BY SPECIALIST

If a patient requires any further treatment, please send them back to our office with this ***completed*** form. All requests must be approved by one of our doctors. ***Please print.***

Today's Date_____

Patient's Name_____DOB_____

Specialist's Name_____

Phone #_____Fax #_____

Insurance Company and Provider #_____

Referral To/For including CPT Codes:

___Follow up visit 99214 / Date of next visit_____/ # of visits_____

___Procedures & Codes_____

___Other (Explain)_____

Diagnosis: ICD-9 Codes_____

Authorized signature_____

INFORMATION REQUESTED BY THE PATIENT

Insurance name and phone #_____

Policy/Identification # and Group #_____

Phone #'s where you can be reached: (H)_____(W)_____

Referral requests need to be approved by a doctor; therefore, we will call you when your referral is ready. Please do not make an appointment with a specialist or facility until we call you. Some insurance companies require that certain procedures be certified and extra time may be needed to process these requests.

Do not ask for backdated referrals. Backdated referrals are a violation of your medical coverage contract and cannot be approved by our office.

Physician Approval_____Date completed_____