FOR OFFICE USE
Provider:_____
Date:_____
Time:_____

RECEIVED

PATIENT REFERRAL FORM

Please fill out the following form (except the parts marked "FOR OFFICE USE") and fax completed forms and copies of insurance cards to the office

Madison Office: P: 256-270-9483 F: 256-325-0340

Patient Name _____ **DOB** _____

Email _____

Insurance Information

Insured Name _____ **DOB** _____

Insurance Contract/Member ID _____ **Group** _____

Insurance Company _____

Any Past/Current Drug Use? _____

_____

Patient or Parent Information

Contact Name _____ **Phone** _____

Address _____

City _____ **State** _____ **Zip** _____

Referral Information

Referred By _____ **Phone** _____

Office Name _____ **Fax** _____

Presenting Problem & Medications _____

FOR OFFICE USE

Preauthorization Required? _____ Authorization No. _____

Limitations to no. of visits? _____ No. of visits authorized _____

Date of authorized visits: Start Date _____ End Date _____

Deductible _____ Met? _____ Co-pay/Co-insurance _____

Providers Covered: M.D._____ Ph.D. _____ LPC _____ LCSW _____ CRNP _____