FOR OFFICE USE

Provider:_____

Date:_____

Time:_____

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
Phone: 256-270-9483
Fax: 256-325-0340

Patient Name _____ DOB_____

Insurance Information

Subscriber Name_____ DOB_____

Insured SS No. _____ Employer_____

Insurance Contract/Member ID No._____ Group No._____

Insurance Company _____

Claims Address (on back of card) _____

_____

Insurance Company Phone No. _____

Patient Information

Contact Name _____ Phone _____

Address_____

City _____ State _____ Zip _____

Referral Information

Referred By _____ Phone _____

Office Name _____ Fax# _____

Presenting Problem (Reason for being seen) _____

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 _____ LICSW _____ CRNP _____