

GROUP INSURANCE PATIENT REFERRAL FORM



REP: _____

PREPARED BY: _____

DATE Recv'd: _____

CLAIMANT INFORMATION

NAME _____ DOB ____/____/____ M/F
 ADDRESS _____ TELEPHONE # () _____
 CITY/ST/ZIP _____ SS # _____ DOA _____

CARRIER INFORMATION

CARRIER _____ CS Rep _____
 ADDRESS _____ TELEPHONE # () _____
 CITY/ST/ZIP _____ FAX # () _____

MEDICAL INFORMATION

DX # 1 _____ DX # 3 _____
 DX # 2 _____ DX # 4 _____

AUTHORIZED PHYSICIANS

DR. NAME _____ PWCODE _____ TENS () GALVANIC ()
 ADDRESS _____ INTERFERENTIAL () BONEGROWTH ()
 CITY/ST/ZIP _____ MICRO-CURRENT () COMBO/IF5000 ()
 TELEPHONE _____ UPIN# _____ EMS 5000/6500 () GARMETS ()
 LICENSE # _____ TAX ID# _____ TYPE OF GARMETS _____
 TAXONOMY# _____ EXP DATE _____ PURCHASE () RENTAL () SUPPLIES ()

INSURED INFO REFERRAL SOURCE

SUBSCRIBER _____ CLINIC _____
 POLICY# _____ ADDRESS: _____
 GROUP# _____ TELEPHONE#: _____
 SS# _____ FAX#: _____
 DOB ____/____/____

BENEFIT INFORMATION

DEDUCTIBLE \$ _____ TOTAL/POCKET _____
 DED. MET YES () NO () Met\$ _____ MET YES () NO () Met\$ _____
 CO PAY % _____ DME MAXIMUM _____
 MAXIMUM PLAN LIMITS _____ EFFECTIVE DATE _____
 HOME PLAN _____ PRE-CERT OR AUTH REQ. YES () NO ()
 WHAT TYPE OF POLICY (HMO,PPO,etc.) _____ PRE-CERT PHONE# _____
 PRE-EXISTING WAITING PERIOD? _____ AUTH# _____
 HIGH DEDUCTIBLE REVERIFIED DATES: _____

NOTES

Auth Purchase / Rental by: _____ Date: _____
 Purchase \$ _____ Rental Price \$ _____ Auth Rental for ____ mos F/up date to
 purchase _____ Negotiated Price if Rental _____

ADDITIONAL NOTES: