Greenbrier Valley Ear, Nose, Throat and Facial Plastic Surgery

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TO ENSURE EFFICIENCY IN OUR OFFICE AND PREVENT INTERNAL BILLING ERRORS WE DO NOT ACCEPT MEDICAL REFERRAL WITHOUT A COPY OF THE FRONT AND BACK OF THE PATIENTS CURRENT INSURANCE CARD. PLEASE DO NOT SEND REFERRAL WITHOUT THIS INFORMATION.

Date of Request: ____________________________ Contact Person: _____________________________

Referring Provider: _____________________________ UPIN: __________ NPI: _________________

Phone Number: _____________________________ Fax Number: _______________________________

Address: _____________________________ City: ______________ State: __________ Zip: _________

REQUESTED INTERVENTION

CONSULTATION	REFERRAL
□ Refer patient back for follow up □ Confirm Diagnosis □ Advise to Diagnosis □ Suggest medication or treatment □ Procedure requested for consideration _______________	□ Assume management of problem and return patient after conclusion of care □ Assume future management of this problem

Reason for Referral: ____

Pre-Certification Required? □YES □ NO Pre-Cert# _______________________________ Visits: __________________

Patient Name: __________________________ Sex: ________ DOB:___________ SS#: __________________

Address: _________________________ City: _______________ State: ____________ Zip:________________

Home Telephone: _______________________________ Cell Phone: __________________________________

Place of Employment:___________________________ Work Phone: ___________________________________

INURANCE INFORMATION

Primary Insurance: ___________________________ Identification # __________________ Group#__________
Name of Insured/Relationship: __________________________DOB:_____________ SS#:________________

Secondary Insurance: _________________________ Identification # __________________ Group#__________
Name of Insured/Relationship: __________________________DOB:_____________ SS#:________________

Appointment Scheduled on __________________ at ________________ by ____________________
□Patient Notified ________________ □ Referring Provider Notified ___________ Staff Initials: _____