NavicentHealth
PhysicianGroup

Incoming Referral Form

Please print legibly

Patient Demographic Information

Last Name:_____ First Name_____ MI _____

DOB___/____/_____SSN_____ Gender: ○ Male ○ Female Phone: _____-_____-_____

Patient's Address:_____ City_____

State/Zip: _____ Is Interpreter Needed? Y / N Language:_____

Insurance/Billing Information

Primary Plan _____Policy#_____ Group#_____

Secondary Plan _____Policy#_____ Group#_____

Subscriber Name_____ DOB___/___/_____ SSN_____

Subscriber Relationship_____, *if guarantor is not the Subscriber, please provide guarantor information*

Guarantor Name_____ Guarantor Relationship_____

Guarantor DOB____/____/_____ Guarantor SSN#_____

○ Authorization NOT Required by Insurance Carrier

○ Required, authorization#_____ Effective Date_____

Clinical Information/Reason for Referral

Chief Complaint/History: _____

Referral Information (*RESIDENTS AND FELLOWS CANNOT BE CONSIDERED REFERRING PHYSICIANS)*

Physician Consult (please indicate preferred physician): _____

Referred by (MD): _____

Phone: _____-_____-_____ Fax:_____-_____-_____ PCP:_____

Address: _____ City: _____Zip_____

Referring MD National Provider Identifier (NPI) _____ (*CMS required*)

This form completed By: _____ Phone: _____-_____-_____

Thank you for allowing our practice to serve your patients' needs! We will call the patient and schedule the appointment. You can expect prompt appointment confirmation via return fax.

Office Use Only

Date Received: _____/_____/_____

Patient Appointment Date: _____ /_____ /_____ Time: _____Physician:_____

Missing Information:

□Insurance Cards □Precertification □Medical Records □Other:_____