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SPECIALIST REFERRAL/ AUTHORIZATION REQUEST

Patients Name: ___________________________ Date of Birth: ________________________

Patients Insurance: ____

Specialty: ________________________ Specialist Name: ___________________________

Appointment Date: ____

Specialist NPI: _________________________________Tax ID __________________________________

Facility Address: ____

Phone #: __________________________________ Fax # ___________________________________

Procedure Code(s)____
(PLEASE Consider and EVALUATE CAREFULLY. ADDING PROCEDURE CODES AFTER THE FACT IS much more difficult and time consuming)

Diagnosis Code(s)____

Length of Treatment or Visit(s)____

Other Notes:

- ❖ Please ensure that all the proper information is provided in a timely manner so that we may issue the referral before the date of the appointment. We cannot issue referrals for the same day!
- ❖ **PLEASE** make sure to **INCLUDE LAST CLINICAL NOTES** in order to approve and substantiate Medical Necessity.
- ❖ ONCE THE REFERRAL/AUTHORIZATION IS OBTAINED PLEASE REFRAIN FROM ANY ADDITIONS OR MODIFICATIONS. Unfortunately, it is very time consuming and inefficient to call the insurance company. It is easier to issue a new referral than it is to make changes to an existing referral.