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Spine Care Specialists

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Rao P. Lingam, M.D., Michael Orzo, M.D., Kalyan Lingam, M.D., Elizabeth Diyanni, PA-C, Angie Weatherwax, PA-C

Date: _____

Patient Name:_____

DOB: _____ Male / Female Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Alternate #: (_____)_____ (C)or(W)

Insurance Information

Primary: _____ Secondary:_____

BWC Claim#: _____ DOI: _____

Note: **We are currently not in network with CareSource, Molina, Medicaid, Aetna Mt. Carmel, OSU PrimeCare, and limited Medicare Advantage Plans.**

Other Info

Patient Diagnosis: _____ ICD-10: _____

Your patient will be scheduled for the first available appointment as specified below with:

Rao Lingam, M.D. Michael Orzo, M.D. Kalyan Lingam, M.D.

Referring Physician Information

Name of Referring Physician: _____NPI: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____ Fax#: _____

**** Would you like SCS to contact your patient with appointment information? Yes / No**

Please fax this form, along with the last office visit, medication log, insurance card, and any diagnostic tests to the location that you wish your patient to be scheduled.
We will return this form with the appointment within 3 business days.

THANK YOU!

PCS OFFICE USE:

Date of Appointment: _____ Packet Mailed: _____

ACCT#: _____