Innovative Spine and Pain Institute

"Where pain stops and life begins"

Referral Form

Referral Date _____ Patient Name _____

Patient Date of Birth _____ Referring Physician/Phone Number _____

Patient Information

Home Phone _____ Cell Phone _____ Email Address _____

Address _____

City _____ State _____ ZIP Code _____

Primary Health Insurance _____ Primary Health Insurance ID _____

Secondary Health Insurance _____ Secondary Health Insurance ID _____

Type of Service Requested (Check One):

- ○ Evaluate and Treat
- ○ Procedure (List Type): _____

If prior authorization/pre-certification is required, list authorization number: _____

Please submit the following information with referral (if available):

- Demographics sheet
- Copy of insurance card or BWC information
- Recent office notes and procedure notes
- All available imaging reports

Please fax this referral to (513) 624-0578 or email to info@innovativespineandpain.com. We will contact your patient to schedule an appointment.

7655 Five Mild Rd. Suite 117
Cincinnati, OH 45230

(513) 624-7525

Info@Innovativespineandpain.com