Patient Referral Intake

ICD 9 Codes: _____

EVAL SCHEDULED: M T W TH F _____/_____ @ _____ am/pm

Patient referred by: Phone Fax Walk-in Date:__/__/___

Referring Physician:
Name: _____ Date of Referral: _____
Phone: _____

What is to be worked on? _____ **AUTO claim/Attorney? Yes No** **Worker Comp claim? Yes No**

PATIENT:
Name: _____ DOB: _____
Phone: _____
Address: _____ **PRE AUTH?** Alt Phone: _____
_____ SS#: _____

PRIMARY Insurance:
Name: _____ Phone #:_____
ID #:_____ Group #:_____

SUPPLEMENT/SECONDARY Insurance:
Name: _____ Phone #:_____
ID #:_____ Group #:_____

SUBSCRIBER (if different from patient):
Name: _____ DOB: _____
Relationship to Patient: _____

VERIFICATION:	**In Network**	**Notes**
COPAY		
COINSURANCE		
DEDUCTABLE		

 # Visits Allowed per Year: _____ **# of Visits used to date**: _____
Modality Limit: _____ **Calendar or Anniversary Year:** _____ (write date please)
Who did you speak to? _____/ **Ref #**_____

VERIFICATION: 2nd / Supplemental	**In Network**	**Notes**
COPAY		
COINSURANCE		
DEDUCTABLE		

Notes_____
_____
_____

Remind the patient to:
Bring- Drivers License, Insurance Cards, Prescription, and comfortable clothes!
Arrive 30 minutes early on Evaluation date if they need to fill out paperwork!