REFERRAL REQUEST FORM

Referring Provider Name: _____

Referring Provider NPI: _____

Referring Provider Phone: _____

Referring Provider Fax: _____

Patient Information:

Patient Full Name: _____

Date of Birth: _____

Patient Address: _____

Patient Phone Number: _____

Insurance Provider: _____

Insurance ID Number: _____

Referral Details:

Reason for Referral / Diagnosis Code(s): _____

Requested Services / Procedures: _____

Preferred Provider or Facility (if any): _____

Authorization and Signature:

I hereby authorize the referral of my patient named above to the requested provider and/or service. I certify that this referral is medically necessary and complies with applicable laws and payer policies. I acknowledge that this form and the information contained herein are subject to verification and audit. I understand my responsibility to provide all relevant clinical information to support the referral and ensure continuity of care. This authorization does not guarantee coverage or payment by any insurance entity.

Referring Provider Signature: _____

Date of Signature: _____

Office Use Only:

Referral Number: _____

Authorization Number: _____

Authorization Status: _____

Reviewer Name: _____

Reviewer Signature: _____

Legal Compliance and Privacy Notice:

This Referral Request Form complies with all applicable United States federal and state laws, including HIPAA privacy and security rules. All patient information contained herein is confidential and is intended solely for the use of

authorized healthcare personnel. Unauthorized use, disclosure, or duplication of this form or its contents is strictly prohibited and may be subject to civil and criminal penalties.

REFERRING PROVIDER SIGNATURE

Signature: _____

RECEIVING PROVIDER SIGNATURE

Signature: _____