**Phone: (713) 913-3764**
**Fax: (713) 913-3790**

# REFERRAL FORM

## REFERRING PROVIDER INFORMATION:

| | |
|---|---|
| Date: | |
| Name: | NPI: |
| Phone: | Fax: |
| Primary Care Provider (*if different*): | |
| Primary Care Provider Fax: | |

## PATIENT INFORMATION:

| | |
|---|---|
| Patient Name: | Date of Birth: |
| Preferred Contact Number: | Patient Email: |
| Reason for Referral/ Special Instructions: | |

## INSURANCE INFORMATION:

| | |
|---|---|
| Primary Insurance: | Secondary Insurance: |
| ID/Claim #: | ID/Claim #: |
| Adjustor/ Attorney (for LOP): | Adjustor/ Attorney Phone: |
| Individual NPI: 1225371586 | Group NPI: 1780274571 |

## PLEASE INCLUDE THE FOLLOWING:

| | | | |
|---|---|---|---|
| **[ ] Patient Demographics** | **[ ] Recent Office Visit Note** | **[ ] Recent Imaging Reports** | **[ ] PCP Referral for HMO Insurance Plans** |