Deaconess Hospital

PROVIDER REFERRAL INFORMATION

PATIENT INFORMATION

**Please complete all fields (NO BLANKS) and attach a copy of ID and insurance cards if available.*

First Name: ____________________ MI: ______ Last Name: ____________________ Gender: ❑ M ❑ F

DOB: __________ Age: _____ SSN: ____________ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Home Phone: ______________ Cell Phone: ______________ Email: ____________________

Exam Name: ____

CPT Code(s): ____

Diagnosis: ____

ICD 9/10 Code(s): ____

Is authorization required? ❑ Y ❑ N If yes, auth #: ______________ Date Range: ______________

Primary Insurance: ____________________ ID#: ______________ GRP#: ______________

Subscriber Name: ____________________ DOB: __________ SSN: ______________

Secondary Insurance: ____________________ ID#: ______________ GRP#: ______________

Subscriber Name: ____________________ DOB: __________ SSN: ______________

Primary Care Provider: ____________________ Referring Provider: ____________________

Does your primary insurance require a referral to see a Surgeon or Specialist? ❑ Y ❑ N

If yes, have you asked your PCP to request one? ❑ Y ❑ N

Date of Service: ______________ Time: __________ Location: ____________________

FOR SURGERY PATIENTS

Surgeon: ____________________ Assistant: ____________________

Patient Status: ____________________ Anesthesia Type: ____________________

OR Time: ____________________ Scheduler: ____________________