Huntsville Surgical Associates

REFERRAL FORM

Referral to:

(256) 265-2895
f: (256) 265-9777

☐ Rony Naijar ☐ Deepak Katyal ☐ Farin Smith ☐ Jeffrey Walker ☐ Kevin Tyler

Referral From: ______________________________

Diagnosis: ______________________________

Scheduled By: ______________________ Person Calling: ______________________

Referral Date: ______________________ Office Number: ______________________

Patient Name: ______________________________

Date of Birth: ______________________ Social Security #: ______________________

Home Address: ______________________________

Home Phone: ______________________ Cell Phone: ______________________

Ins/Primary Name: ______________________________

Policy#: ______________________ Grp: ______________________

Date of Appointment: ______________________

Insurance Information *(provide patient information unless patient is a minor, then provide guarantor's information)*

PRIMARY INSURANCE

Insurance name: ______________________ Relationship to patient: ______________________

Subscriber's name: ______________________ Copay amount: ______________________

Subscriber ID/Contract Policy #: ______________________ Group #: ______________________

Subscriber's SSN: ______________________ Subscriber's DOB: ______________________

Subscriber's Employer: ______________________ Employer's Phone: ______________________

SECONDARY INSURANCE

Insurance name: ______________________ Relationship to patient: ______________________

Subscriber's name: ______________________ Copay amount: ______________________

Subscriber ID/Contract Policy #: ______________________ Group #: ______________________

Subscriber's SSN: ______________________ Subscriber's DOB: ______________________

Subscriber's Employer: ______________________ Employer's Phone: ______________________

Instructions: *(Check off to verify done)*

☐ Referral requested (Tricare, HealthSpring, Medicaid etc.)
☐ Referring physician office to fax all records related to patient's condition
☐ Request office to send copy driver's license and insurance card with records
☐ Patient to bring all medications or list of medications to appointment
☐ Patient to bring co-pay and/or $75 if self-pay
☐ New patient packet sent

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Staff Initials/Date/Time