

Referral to:

Matthew Hunt Douglas Downey Marc Zelickson Veeraiah Siripurapu

1041 Balch Road, Ste. 350
Madison, AL 35758
(Madison Medical 1)

201 Sivley Road, Ste. 330
Huntsville, AL 35801
(Blackwell Medical Tower)

Referral From: _____

Diagnosis: _____

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)*

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: _____

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 \$ if self-pay
- New patient packet sent

Staff Initials/Date/Time