Kedar K. Deshpande, M.D., FAAPMR
Board Certified by the American Academy of Pain Medicine
Board Certified by the American Academy
of Physical Medicine and Rehabilitation
Jamie Weaver, CNP
Benjamin Flaherty, PA-C

NEW PATIENT REFERRAL FORM

Please send medical records related to referral, imaging reports and insurance information.
Complete and fax to: 614-956-1382

PATIENT INFORMATION:

Patient's Name: _____ Male or Female

Street Address: _____

City, State and Zip: _____

DOB: _____ SS#: _____ Marital Status: _____

Home phone: _____ Alternate #: _____

PRIMARY INSURANCE INFORMATION: If HMO insurance, documentation of authorization must accompany this form. We are not a third-party biller.

Primary Insurance: _____

Policy ID#: _____ Group No: _____

Subscriber Name: _____ DOB: _____

Secondary Insurance: _____

Policy ID#: _____ Group No: _____

Subscriber Name: _____ DOB: _____

BWC Visit: Yes or No Claim and DOI: _____ *Please fax approved C9

*Please contact our office for a complete list of insurance carriers accept by our office

REFERRAL INFORMATION:

Is this a referral for: PHYSICIAN ADDICTION COUNSELING

Reason for referral _____

PHYSICIAN INFORMATION:

Referring Physician: _____ NPI #:_____

Contact: _____ Phone #: _____ Fax #:_____

Primary Care Physician: _____ Phone: _____

Location for Appointment:

_____ 6810 Perimeter Drive, Suite 200-A, Dublin 43016 Phone: (614) 956-1189

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