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Interventional Spine Specialist
Interventional Pain Management
Physical Medicine & Rehabilitation

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 PSYCHOLOGY

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

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