ADVANCED RHEUMATOLOGY

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REFERRAL REQUEST

Date: _____ Reason: _____

CHOOSE A PROVIDER &

- ◯ First Available Provider (fastest option)
- ◯ Dr. Mohan
- ◯ Dr. Virupannavar

CHOOSE LEVEL OF URGENCY

Clear Form

- ◯ **Routine Referral**
- ◯ Urgent Referral (within a 1-2 business days)

note: urgent referrals are accepted at physician discretion & physician may need to speak with the referring provider

PATIENT INFORMATION

Name: _____ DOB: _____

Address: _____

Preferred Phone #: _____ Alt. Phone #: _____

Patient's PCP: _____ PCP Phone: _____

INSURANCE INFORMATION (PLEASE INCLUDE A COPY OF ALL CARDS)

Primary Ins: _____ Member ID: _____ Group: _____

Subsriber Name: _____ Subscriber DOB: _____

Secondary Ins: _____ Member ID: _____ Group: _____

Subsriber Name: _____ Subscriber DOB: _____

PLEASE ATTACH A COPY OF ALL LISTED ITEMS: (incomplete referrals will be returned for more info)

1) Visit Notes 2) Most Recent Labs 3) Most Recent Radiology

REFERRING OFFICE INFORMATION

Referring Provider(s): _____

Address: _____

Phone: _____ FAX: _____

Whom from your office should we contact with questions and updates? _____

If you have a direct/backline phone number we may use, please list here: _____

NOTES ABOUT REFERRAL (if applicable): _____

updated: Mar 2022

We accept BCBS, BCN, McLaren, Medicare, PHP, Priority Health, SCN, SPHN, Tricare & Most Commercial Insurances
We are NOT accepting new Medicaid or Self Pay patients.

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