

REFERRAL GUIDELINES FOR A VISIT WITH A SPECIALIST PHYSICIAN

I AM A MEMBER ENROLLED IN AN INSURANCE THAT REQUIRES MY PRIMARY CARE PHYSICIAN (PCP) TO OBTAIN A REFERRAL # OR A FORMAL AUTHORIZATION FROM MY INSURANCE CARRIER TO SEE SPECIALIST.

I ALSO UNDERSTAND THAT I HAVE AN OBLIGATION TO BRING AND/OR PROVIDE THIS REFERRAL AT TIME OF SERVICE TO ENSURE PROPER REIMBURSEMENT TO MY NEUROLOGIST DR:_____

TELEPHONE #

I AM ALSO BEING MADE AWARE THAT SERVICES RENDERED WITHOUT PROPER REFERRAL (AS ESTABLISHED BY MY INSURANCE CO.) WILL RESULT IN THE PATIENT BEING RESPONSIBLE FOR PAYMENT.

LAST

FIRST

INITIAL

Today's Date:_____

Patient's Signature_____