Comprehensive Allergy & Asthma Care

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Fax 914-337-8204

REFERRAL FORM

Please complete this form and fax it back to our office along with the following information. Providing this information will expedite the referral process. Note: the following is necessary for an appointment to be scheduled, Thank You.

- DEMOGRAPHICS SHEET
- INSURANCE CARD (ACTUAL COPY) BOTH SIDES
- INSURANCE AUTHORIZATION (SANTE,TRICARE,KEY MEDICAL,WORKERS' COMPENSATION)
- MD NOTES (MOST RECENT) TYPED
- CURRENT LIST OF MEDICATIONS

****PLEASE DO NOT FAX
NO MORE THAN 15 PAGES
IF MORE THAN 15 PLEASE MAIL****

PATIENT INFORMATION:

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____ SEX: M F

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ CELL/MESSAGE #: _____ WORK#: _____

DOB: _____ SSN: _____ email: _____

DIAGNOSIS (NOT THE CODE): _____

INSURANCE INFORMATION:

PRIMARY INSURANCE CO.: _____

SECONDARY INSURANCE CO.: _____

WORKERS' COMP INS. NAME: _____

WORKERS' COMP CLAIMS ADDRESS: _____

ADJUSTER NAME: _____ PH#: _____ CLAIM #: _____

PHYSICIAN INFORMATION:

REFERRING MD: _____ CONTACT NAME: _____

PHONE #: _____ FAX #: _____ DATE: _____