Today's Date: _____/_____/_____
Received By: _____

Date of Referral Appointment: _____/_____/_____
Date of Last Office Visit: _____

Referral Request Worksheet

Your primary care physician has referred you to a specialist/for a procedure. It is your responsibility to verify with your insurance carrier if a referral/pre authorization is required for your visit. If so, please complete this worksheet. **We must be selected as your PCP with your insurance carrier in order to process this request.**

Please follow these referrals request guidelines:

1. Your primary care physician must approve your referral request **before** you make the referral appointment.
2. Make the appointment with the referral doctor a minimum of **7 business days** before requesting the referral authorization from our office.
3. Complete the patient information and referral information sections of this Referral Request Worksheet. Please print legibly. If we cannot read your information, we cannot process your referral. Incomplete referral requests will not be processed.
4. After completing this worksheet, you may request the referral one of two ways:
   - **Call** the office at (248) 477-5608 and relay the information on this Referral Request Worksheet.
   - **Fax** this worksheet to our office at (248) 427-0010

If you have any question, concerning your referral, you may contact us at (248) 477-5608 during normal business hours: Monday through Friday, 9:00 am – 5:00 pm. If you haven't heard from our office, assume your referral has been processed successfully.

Patient Information

Name: _____ Date of Birth: _____/_____/_____
First (Legal Name – NO "Nicknames" Please) Last

Home #: (_____) _____ Work #: (_____) _____ Cell #: (_____) _____

Primary Care Physician: (Please Check One) ____Dr. Finn ____Dr. Haller ____Dr. Hug ____Dr. Kemennu ____Dr. Kakish ____Dr. Martilotti ____Dr. Molnar

Primary Insurance: (Please Check One) ____Aetna ____BEP ____Blue Cross/Blue Shield ____Blue Care Network ____Cigna ____DMC ____HAP ____Health Plus ____Priority Health ____United Health Care ____Other: _____

Policy/Contract #: _____

Referral Information

The referring Dr. may not being your PCP, In this case, we need to know the name of the ordering/referring Dr.

Referred to: _____ (_____) By Dr: _____
First Name Last Name Specialty

Facility: ___Beaumont Royal Oak (P00196) ___U of M (P00029)

___Other/**NPI #**:_____

Phone #: (_____) _____ **Fax#:** (_____) _____ Office Location: _____
Required City

Reason/Type of Referral: (Please Check One)
___ Office Visit/ Consultation for (reason): _____
___ Physical Therapy: _____ times a week for _____ weeks
Injury/DX: _____

For Office Use Only

Diagnosis Code(s): _____ Procedure Code(s): _____ Referral Authorization #: _____

Dates Valid: _____ Referral Authorization #: _____