499 Gloster Creek Village, Suite A-1
Tupelo, MS 38801
Phone: (662) 432-0700
Fax: (662) 842-0568

UROLOGIC REFERRAL REQUEST

Referring Provider Information			
Provider Name:		Phone Number:	
Provider's NPI Number:			
Provider Address:		City/State/Zip:	
Clinic Contact Person:		Fax Number:	

Appointment Request	
Specific Provider Requested:	Patient Diagnosis:
Reason for Referral:	
Preferred Clinic Location:	____ 499 Gloster Creek Village, Suite A-1, Tupelo, MS 38801
	____ 203 Alcorn Drive, Corinth, MS 38834
	____ 1105 Earl Frye Blvd, Amory, MS 38821

Patient Demographic Information			
Patient Name:		Gender:	
Address:		City/State/Zip:	
Date of Birth:		Social Security#:	
Phone Number(s):			

Patient Insurance Information			
Primary Insurance:		**Secondary Insurance:**	
Contract#:		Contract#:	
Group ID#:		Group ID#:	
Primary Insured's Name:		Primary Insured's Name:	
DOB:		DOB:	

DOCUMENTATION:

To expedite your referral the following documentation is required: CLINIC NOTES, HISTORY & PHYSICAL, PATHOLOGY REPORTS, PREVIOUS PROCEDURES, LABORATORY RESULTS, RADIOLOGY REPORTS, OPERATIVE REPORTS, COPY OF PATIENT'S INSURANCE CARDS.

Please provide Insurance Referral/Prior Authoriation PA number _____

The patient will be notified of appointment by Urologic staff.

Urologic Office Use Only:

___ copy of insurance cards received

Appt date/time: _____

___ notified patient of appointment

Notes: