urologic

Internal Use:	ROUTINE	URGENT
Appt Date:	Time:	
Provider:		

Urologic staff will notify patient of appt

UROLOGIC REFERRAL REQUEST

Date of Referral:_____

Do NOT use form for kidney stones or other emergency - please call (662) 432-0700 for an appointment.
An appointment letter will be mailed to the patient. Please contact the patient with their appointment.

REQUESTING (REFERRING) PROVIDER INFORMATION

Requesting Provider Name and **NPI#**	Requesting Provider Address (street, city, state, zip)

Requesting Provider Telephone	Requesting Provider Fax Number	Clinic Contact Person

APPOINTMENT REQUEST

□ First Available Specific Provider: _____

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 Boulevard
Amory, MS 38821

PATIENT INFORMATION MUST FAX PATIENT DEMOGRAPHIC

Patient Name (First, Middle Initial, Last)	Patient Phone Number(s)

Patient's Date of Birth (mm/dd/yyyy)	Patient's Social Security Number	Gender
		□ Male □ Female

INSURANCE INFORMATION MUST INCLUDE FRONT/BACK COPIES OF INSURANCE CARDS

Primary Insurance	Contract Number:_____ Group ID:_____ Primary Insured's Name: _____ DOB:_____

Secondary Insurance	Contract Number:_____ Group ID:_____ Primary Insured's Name: _____ DOB:_____

Please provide Insurance Referral/Prior Authorization PA Number: _____

To expedite your referral the following documentation is REQUIRED: CLINIC NOTES, HISTORY & PHYSICAL, LABORATORY RESULTS, RADIOLOGY REPORTS, PERTINENT OPERATIVE REPORTS, PATIENT DEMOGRAPHICS, FRONT AND BACK COPIES OF INSURANCE CARDS. Please note your request for referral will not be processed until records are received. Please fax pertinent documentation with this referral form to: (662) 842-0568.