Today's Date:_______/_______/_______ **Date of Referral Appointment:** _______/_______/_______

Received By:___________________________

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 referral 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 full 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 248-477-6850

If you have any questions concerning your referral, you may contact us at 248-477-5608 during normal business hours: Monday through Friday, 9am-5pm. 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 Physican: (Please Check One)

___Dr. Finn	___Dr. Haller,	___Dr. Hug,	___Dr. Popp,	___Dr. Kemennu,	___Dr. Kakish
	Aetna: 4507166	Aetna: 4675032	Aetna: 7495192		Aetna: 7300592
	Bcn: 0633700	Bcn: 0637903	Bcn: 0633550		Bcn: 0634405
	Hap: E41304	Hap: F93999	Hap: H13805		Hap: H37303
	MCare: B2881	MCare: C3394	MCare: 16088		MCare: 17555

Primary Insurance: (Please Check One) ___Medicare, ___Aetna, ___Blue Cross Blue Shield, ___Blue Care Network, ___Cigna, ___HAP, Other: ____________________________

Policy/Contract #: ________________________________

Referral Information

The referring Dr. may not be 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), ___Beaumont Troy (P00226), ___Beaumont West Bloomfield (Image Center), ___U of M (P00029), ___Other:________________________________

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

Reason/Type of Referral: (Please Check One)

___Office Visit/Consultation for (reason):________________________________

___Other for (procedure, test, etc.):________________________________

___Physical Therapy: ________ times a week for ________ weeks

Injury/DX:________________________________

Office Use Only

Referral Doctor's Provider ID#______________ Diagnosis Code(s)______________ Procedure Code(s)______________

Referral Authorization #______________________ Dates Valid ______________________