6296 Rucker Road, Suite A
Indianapolis, IN 46220
phone: 317-550-3043
fax: 855-845-3260

For referrals, the following information is needed and can be faxed to 855-845-3260

- ⌈ Facesheet or other document containing patient demographics and contact information
- ⌈ Valid order from physician (patient full name, dx, services ordered, signed and dated)
- ⌈ Contact information, including fax number, for physician office making the request
- ⌈ Recent notes from the physician regarding the need for referral
- ⌈ A copy of the patient's insurance card(s) front and back

Order Information

Patient Name: _____ DOB: _____ Phone:_____

Gender: _____ Marital Status: _____

Address: _____ City: _____ State: ____ Zip: _____

Alternate contact: _____ Relation: _____ Phone: _____

Date of Order: _____ Referring Diagnosis: _____ ICD code: _____

Referral Question: _____

Referring Physician: _____ Phone:_____ Fax:_____

Address of Physician: _____ City/State: _____ Zip: _____

Primary Care Physician for Patient: _____ Phone: _____

Insurance information (from insurance cards)

Primary Policy Holder _____ Relation/DOB_____/_____ SSN#_____

Policy Holder's Phone#_____ Policy Holder's Employer_____

Primary Payer_____ Benefits phone# on card_____

Secondary Policy Holder _____ Relation/DOB_____/_____ SSN#_____

Policy Holder's Phone#_____ Policy Holder's Employer_____

Secondary Payer_____ Benefits phone# on card_____

_____ _____
Ordering Physician Signature Date

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