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Referral Request

We **DO NOT FAX** or **BACK DATE** referrals

Please allow **2-3 business days** to process **REFERRAL REQUESTS**

Please allow **5 business days** to process **PRIOR AUTH REQUESTS**

Today's Date: _____

Patient Name _____

Date of Birth _____

Insurance Type: _____

ID #: _____

Specialist Name: _____

Appointment Date: _____

Facility (if applicable): _____

Reason for Appointment: _____

Best way to reach you (home phone, cell, email) _____