

Request for Consultation/Procedure

Fax 517-483-7533

Request From: _____ **Phone #:** _____ **Fax #:** _____
Physician's full name

Patient Name: _____ New Pt. Prev. Pt.
Last First Middle

SS# _____ **DOB** _____ **Sex:** Male Female

Address: _____ **City:** _____ **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____ **Hours:** _____

Insurance Type: BC/BS Medicare SPHN BCN-HC Medicaid PHP Messa
 Blue Preferred Plus Care Choice Other _____

Contract # _____ **Authorization #** _____

Subscriber Name _____ **Relationship to Patient** _____

Request for:

Consult Consult and Treatment
 Referral Procedure _____
(If Procedure Ordered – Weight) _____

Diagnosis for Consult/Procedure: _____

Are there any current test results available? Yes, please list and fax with this request. No

TCI Physician Requested: _____ **Priority:** First Available Needs to be seen within: _____

Referring Physician Signature: _____

Confirmation of Appointment:

Appointment Date: _____ **Time:** _____ **with Dr.** _____

Comments: _____