NEW Patient Contact Information
Mobile / Daphne / Dothan
referrals@dynamicpainandwellness.com
FAX (877) 413-5104
PHONE (850) 226-6801

NEW PATIENT REFERRAL FORM

A complete referral form will ensure efficient scheduling for your patient.

DATE: _____

REFERRING DR: _____NPI:_____

PHONE: (_____)_____ FAX: (_____)_____

ADDRESS: _____

PATIENT INFORMATION

NAME: _____

DOB: _____ SSN: _____ GENDER ❑ M ❑ F

PHONE: (_____) _____ ALT PHONE: (_____) _____

ADDRESS: _____

DIAGNOSIS CODE and DESCRIPTION: _____

_____

INSURANCE INFORMATION

CARRIER: _____ ❑ PPO ❑ HMO

SUBSCRIBER NUMBER: _____

REFERRAL/AUTHORIZATION NUMBER: _____

DATES OF SERVICE APPROVED: _____- _____

CPT CODES APPROVED: _____ 99204 AND 99214_____

SECONDARY INSURANCE INFORMATION

CARRIER: _____

❑ PPO ❑ HMO SUBSCRIBER NUMBER:

_____

ADDITIONAL INFORMATION

IS THIS TREATMENT RELATED TO A MOTOR VEHICLE ACCIDENT? ❑ YES ❑ NO

IS THIS TREATMENT RELATED TO A WORKER'S COMP CLAIM? ❑ YES ❑ NO

IS THIS CLAIM STILL OPEN? ❑ YES ❑ NO